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ABSTRACT

This handbook was written to encourage and assist school districts, schools, and community-based organizations to respond to the growing need for adolescent pregnancy prevention activities in the middle grades. It reflects the experiences of adolescent pregnancy prevention programs across the country, particularly those of the eight Urban Middle Schools Adolescent Pregnancy Prevention Program projects. It describes many of the lessons learned in these projects about appealing to at-risk youth, overcoming the barriers to implementation, working collaboratively, and dealing with controversy. Part 1 looks at why adolescent pregnancy prevention should take place in the middle grades. Implications for risk prevention strategies are discussed. Changes are looked at for meeting developmental needs in middle grades education. Elements of an effective pregnancy prevention program are outlined, and collaboration is discussed as a means to better meet the needs of adolescents. Part 2 contains information about pregnancy prevention strategies, including family life and sexuality education, postponing sexual involvement, counseling, peer education, school-based clinics, service learning, mentoring, and multicomponent programs. Part 3 discusses program implementation and includes information about planning, handling controversy, promoting effective collaborations, staff development, funding, and evaluation. Appendices include a case study, a summary of evaluation of pregnancy prevention strategies, a summary of statistics on teenage sexuality and pregnancy, and a list of resource organizations. (LLL)

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Building Life Options

School-Community Collaborations for Pregnancy Prevention in the Middle Grades

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Building Life Options

School-Community Collaborations for Pregnancy Prevention in the Middle Grades

Elayne Archer
and
Michele Cahill

Academy for Educational Development
1991

The Academy for Educational Development (AED) is a private, nonprofit organization that addresses human development needs through education, communication, and information. Under grants and contracts, AED operates programs for government and international agencies, educational institutions, foundations, and corporations. Since its founding in 1961, AED has conducted projects throughout the United States and in more than 100 countries in the developing world. In partnership with its clients, AED seeks to increase access to learning, transfer skills and technology, and support institutional development.

The School and Community Services Division has a strong commitment to excellence and equity in education and to developing links between schools and community agencies that increase educational and development opportunities for at-risk youth across the United States. Staff and consultants have extensive experience working with large urban school systems, community organizations, and foundations and other funding agencies on programs adressing critical educational issues such as dropout prevention, adolescent pregnancy and parenting, literacy, and youth employment and training.

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Foreword

In the early 1980s, I was part of a team that visited several cities to meet with school and community leaders to determine their readiness to get involved in pregnancy prevention activities at the middle grades level. We expected that these people would present us with a litany of obstacles and barriers, and that the fear of controversy would dominate the conversation. Instead what we heard was one question: "When can we start?" In many school systems, epidemics of the problems confronting adolescents — the consequences of sex, drugs, violence, racism and poverty — were affecting younger and younger children, placing burdens on middle grades personnel that were seriously compromising their efforts to teach.

Thus, the Urban Middle Schools Adolescent Pregnancy Prevention Program (UMSAPPP) was born, stimulated by the joint efforts of the Carnegie Corporation and the Ford Foundation, and most effectively parented by the Academy for Educational Development. Much to our delight, many school districts wanted to participate, and it was difficult to select the eight finalists. From this publication, you will learn about the eight school districts with collaborative life options programs that jointly addressed building the capacity to prevent pregnancy and the motivation to succeed in school.

The UMSAPPP experience provides us with valuable insights into addressing the phenomenon of cultural lag: the fact that individual behaviors change much more rapidly than the culture and the society in which the behaviors take place. Research has substantially documented that premarital sexual intercourse has become normative behavior prior to high school graduation. Whether we like it or not, most teens are doing it. We know that some middle grades children are, in fact, also engaging in very high risk behaviors, and that all middle grades children are exposed to explicit sexual materials through the media and from their peers. The UMSAPPP programs demonstrate that our society can deal with these changed conditions and respond to them in a rational and honest way. A simple truth emerges from these pages: caring people using sensible approaches can change the course of children's lives.

This handbook represents a direct response to the need for middle grades schools to address sexuality issues. As practitioners and policymakers know all too well, no magic formula will change either individual behavior or institutional behavior. The social environment today places incredible demands on the people who work with children, especially in disadvantaged communities. This volume will instruct educators and youth workers and encourage concerned citizens to expand the opportunity structure for young adolescents. I hope that schools and community agencies will make good use of this handbook to build creative, collaborative approaches to improving the quality of life for our vulnerable young people.

Joy Dryfoos
Chair, UMSAPPP Advisory Board

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Many people contributed to *Building Life Options: School-Community Collaborations for Pregnancy Prevention in the Middle Grades*. Notably, the members of the Urban Middle Schools Adolescent Pregnancy Prevention Program (UMSAPPP) Dissemination Phase Advisory Board — Joy Dryfoos, Raejean Kanter, Adrian Lewis, Jay Lodie, Beverly Perry-Morgan, Karen Pittman and Michaele White — offered much valuable advice and insights and reviewed drafts of the manuscript. In particular, Joy Dryfoos and Karen Pittman provided analysis and support without which this handbook could not have been produced. In addition, Manuel Gutierrez, the program evaluator and documenter for the first phase of UMSAPPP, made many excellent suggestions.

Thanks are also due to the many individuals who participated in UMSAPPP over the past five years: school district superintendents, who demonstrated leadership in initiating pregnancy prevention activities at the middle grades level; project directors, staff, and teachers, who pioneered innovative approaches to improving middle grades education; staff in community-based agencies, who worked energetically in collaboration with schools to improve student life options; and students, who were a source of inspiration to all of those who worked with them daily. Specifically, we are indebted to UMSAPPP project directors and staff who shared their experiences and insights with us: Diane Colby, Erma Gibbs, Dorothy Greene, Greta Gustavson, Virginia Hathaway, Marilyn Hurwitz, Jennifer Hill-Young, Future Jackson, Melinda Jaggi, Alan Johnson, Napoleon Jordan, Raejean Kanter, Colleen Landazuri, Jay Lodie, Evelyn Lucero, Dorothy Patterson, Beverly Perry-Morgan, Pat Settimi, Sam Wallace, and Shirley Wilson.

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Several of our colleagues at the Academy for Educational Development also contributed to this handbook: Anne Galleta provided valuable comments on the original draft and helped with the section on parental involvement; Alex Wilkie did research on pregnancy and early adolescence; Chenda Fruchter and Paula Vincent worked tirelessly on the resources; and Wanda Dallas and Dorothy Nixon provided much-needed word-processing support. Betty Mauceri did an excellent job in formatting and producing the final copy.

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Michele Cahill
UMSAPPP Program Director
1985–1991

Elayne Archer
Senior Consultant

The Urban Middle Schools Adolescent Pregnancy Prevention Program

Background

Building Life Options: School-Community Collaborations for Pregnancy Prevention in the Middle Grades is based in part on the work of the Urban Middle Schools Adolescent Pregnancy Prevention Program (UMSAPPP), a national demonstration program initiated by the Academy for Educational Development (AED) in the fall of 1985, with support from the Carnegie Corporation and the Ford Foundation. UMSAPPP began against a now-familiar background: concern about increased sexual activity and pregnancy among young teens; a growing awareness of the connection between too-early pregnancy and parenthood and dropping out of school; and an increasing understanding of the crucial nature of the middle grades in determining students' educational futures. The program was based on three assumptions:

- Schools are central to any successful strategy for adolescent pregnancy prevention because they provide the greatest access to the young people in need and because academic achievement can have an important impact on the likelihood of early parenthood.
- Effective adolescent pregnancy prevention strategies must focus on the middle grades population because teens are initiating sexual activity at earlier ages than in the past and because it is in the middle grades that many students lose interest in school and, in effect, drop out.
- To be effective, prevention strategies must be designed and carried out in collaboration with community-based organizations: such organizations often have better access to families than do schools and are critical vehicles for creating a positive impact on community climate. They also have a wider range of options in designing programs and strategies, and are not restrained by the kinds of bureaucratic limitations with which schools must often contend.

UMSAPPP sought to increase awareness among educators about the high-risk nature of early adolescence, to encourage new institutional arrangements responsive to the needs of young people, and to stimulate and strengthen school-community collaborations for adolescent pregnancy prevention in the middle grades.

In October 1985, AED invited 40 large urban school districts to apply for $5,000 planning grants to design adolescent pregnancy prevention strategies in their middle grades

schools. Some 34 school districts submitted applications, and the Academy chose 15 to receive planning grants. Among the criteria for selection were evidence of *need* — the presence of high rates of adolescent pregnancy and child poverty in a school district — and evidence of *capacity* to develop and implement a collaborative program.

In June 1986, the program awarded eight of these school districts two-year grants of approximately $75,000 a year to implement pregnancy prevention activities in their middle grades schools in the next academic year. These districts were: Atlanta; Boston; Detroit; Kansas City, Missouri; Los Angeles; Milwaukee; Norfolk; and Oakland. During the initial two years of operation, the eight-city project implemented pregnancy prevention programs and interventions at 55 middle grades schools, involving 9,100 students and 975 school staff. While adhering to a "life options" approach (described below), each project developed its own strategies on the basis of perceived needs, resulting in a diversity of activities. These included family life/sex education; mentoring, cultural, and after-school programs; satellite clinics; and teacher development and parent involvement activities. After two years, small grants allowed projects to continue activities. In some cases, this meant that projects could expand activities to include more middle grades schools; in others, it meant intensifying activities within one or two schools.

All UMSAPPP projects involved collaborations with community and social service agencies: Planned Parenthood, the YWCA, the Urban League, institutions of higher education, and other community-based agencies concerned with the health and welfare of children and families. These collaborations, as program planners expected, were extremely valuable: they broadened the range of pregnancy prevention activities, increased the resources available to schools, and, in general, lent much-needed support to educators.

At every stage, all projects received technical assistance from AED in a variety of ways, notably through conferences, mailings, and site visits. Technical assistance helped schools develop and implement programming that was developmentally appropriate and informed by recent research about middle grades education. In addition, it helped schools to work collaboratively and to overcome various barriers — particularly the controversy that implementing pregnancy prevention activities in the middle grades often engenders. Annual conferences provided project staff with linkages to researchers and to the resources of national agencies. This afforded individual programs and staff a continuous flow of information about pregnancy prevention and middle grades reform. Annual conferences also offered projects a valuable network of school district representatives, educators, and staff in youth-serving agencies with whom to share information.

UMSAPPP's primary goal was to increase the capacity of urban school districts and community-based agencies to help adolescents avoid premature pregnancy and parenting. The expectation was not that individual projects would have an impact on rates of teen pregnancy at the middle grades level, but rather that they would enable students to avoid parenthood throughout their teen years. Nevertheless, projects were encouraged to try to assess their effectiveness. Because of the diversity of projects, each site developed its own documentation plan. While the sites were urged to identify a number of outcome measures and to collect data to assess project impact along these measures, these efforts tended to be preliminary and exploratory because of budgetary constraints. However, a sense

emerged from these evaluations that concerned staff with innovative programming can effectively reach high-risk youth.

UMSAPPP activities also served as a catalyst for middle grades restructuring activities in several instances. Most notably, in Los Angeles, on the basis of Operation Bright Future's success with a small number of students and the experience of the principal at UMSAPPP national conferences, Hollenbeck Junior High undertook a major school restructuring effort in 1989-90 to become more responsive to the needs of early adolescents. The school, which had an enrollment of 2,300 students, was divided into five "houses," or casitas, each consisting of 450 students and a team of 15–17 teachers, plus administrators and counselors. The effects were dramatic: teacher morale rose, discipline problems declined, and students' relationships with their teachers improved. The largely Hispanic parent population related well to the concept of casita, and this made it easier for them to feel comfortable communicating with teachers and staff.

The major purpose of this handbook is to encourage school districts, schools, and community-based organizations to respond to the growing need for adolescent pregnancy prevention activities in the middle grades, and to assist them in doing so. It reflects the experiences of adolescent pregnancy prevention programs across the country, particularly those of the eight UMSAPPP projects. It describes many of the lessons learned in these projects about appealing to at-risk youth, overcoming the barriers to implementation, working collaboratively, and dealing with controversy.

This handbook is based on the assumption that effective pregnancy prevention activities must be developmentally appropriate — that is, reflective of and responsive to the nature and needs of early adolescence. It is also based on lessons learned from several decades of the sex education and family planning movements: that providing young people with information about sexuality, pregnancy, and contraception — and even with access to contraception — is necessary but not sufficient. Young people need both the *capacity* and the *motivation* to avoid risk behaviors. Thus, any effective pregnancy prevention intervention must include both strategies that improve young people's capacity to avoid risk behaviors — family life/sex education, abstinence education, individual and group counseling, activities enhancing decision-making skills and assertiveness, and improved access to contraception — and activities that enhance their motivation for doing so — academic enrichment and remediation, career awareness, mentoring and service learning. Such programming typifies the "life options" approach to pregnancy and risk prevention that researcher Joy Dryfoos first described in 1984.

This approach has several advantages. It treats sexuality as a normal part of adolescent development. It takes into account the many factors that affect a young person's decisions regarding sexuality and pregnancy and is rooted in an understanding of the interrelatedness of risk behaviors. It helps young people understand the connections between school achievement and future educational and employment options, and helps build these connections by enhancing young people's school performance. It appeals to parents, as one UMSAPPP family life teacher said, "because we respect the young people, and we help them to understand and deal with all the changes they're going through." Lastly, and perhaps

most important, the life options approach empowers young people to become active agents in their own positive development.

Pregnancy prevention activities employing such an approach should be part of middle grades education for all students — not just those considered at high risk. Further, activities and programs that can help young people avoid too-early sexual activity and pregnancy can also help them avoid other risk behaviors with possible negative long-term consequences. Finally, initiating such activities can play a vital role in enhancing middle grades education in general.

UMSAPPP Project Descriptions

Atlanta: Teen Intervention Project (TIP)

The major goal of Atlanta's Teen Intervention Project was to enhance the impact of the existing family life curriculum by improving the decision-making skills of sixth and seventh grade students. Two major interventions were aimed at achieving these goals: an extensive mentor program and school support teams. Through collaborations with local colleges, fraternities, and businesses, TIP provided mentors for many students. Initially, the focus was on providing African American male mentors for young boys growing up in female-headed households; later, girls received mentors. Mentors met with students on an ongoing basis and served as both role models and friends. TIP also established school support teams consisting of the school nurse, a counselor, and a family life teacher. These teams, which received special training in sexuality and family life education, held small group sessions to conduct in-depth discussion of sexuality issues raised in the large assemblies that were a regular part of the family life education curriculum. In many cases, staff from collaborating community-based agencies made these presentations. TIP also used peer counselors because "kids use the right words with kids." The project developed a focus on AIDS education with school support teams receiving four days of comprehensive AIDS training. An evaluation of TIP by the Atlanta public schools indicated that no pregnancies occurred among students receiving program services, as opposed to 25 among students not receiving them. In addition, compared with the non-participants, TIP students showed greater awareness of the implications of risk-taking behavior, had better attendance records, and achieved grade point averages that were one-half point higher. The project included 10 elementary schools with grades six and seven and nine middle schools.

Boston: Life Planning Education (LPE)

Through the UMSAPPP project, the Boston public schools introduced family life education in 1988, using the Center for Population Options curriculum Life Planning Education; ultimately, one semester of family life education became a requirement of the citywide Boston Education Plan. Each UMSAPPP school established a support team to promote pregnancy prevention and related activities and to foster collaborations with community-based agencies, businesses, and universities. Teams consisted of teachers, counselors, administrators, and representatives of involved local agencies and businesses. Each

school selected one major collaborating agency with which to plan school-based prevention activities. LPE collaborated with other prevention efforts, including AIDS education, substance abuse and violence prevention education, student mediation programs, and a student call-in show on cable TV addressing health issues. An important activity of LPE that stimulated student participation was the annual CityWide Teen Forum, an event planned and run by students, with high school students acting as mentors to middle grades students. LPE received a state Department of Education grant to provide comprehensive health education and support services; and LPE staff were invited to help draft the Boston Initiative Teen Pregnancy Prevention Report for the Governor's Challenge Fund to serve as a teen agenda through the year 2000.

Detroit: Teen Scene

After-school drop-in teen centers established in the first phase of UMSAPPP provided programming and activities in two middle schools. Students in the centers met in two groups — grades 7–8 and grade 9 — where they received health education and had opportunities to discuss issues related to human sexuality, reproductive health, and pregnancy prevention. The project operated the groups in collaboration with the Detroit Department of Public Health. Another focus of Teen Scene programming was on providing a wide range of cultural events and activities to instill cultural pride and enhance students' sense of self-efficacy. This effort entailed a major collaboration with OmniArts, an umbrella group of community-based artists and cultural organizations. Activities included helping students write scripts for, and perform in, their own videos. A number of successful collaborations took place, such as a project with the YMCA in which 45 medical interns provided drug abuse prevention education.

Kansas City, Missouri: Project Phoenix

Project Phoenix initiated a comprehensive approach to health education and pregnancy prevention through a major collaboration with the Adolescent Resources Corporation (ARC). One of the chief activities of this collaboration was the establishment of two satellite clinics in junior high schools, run by staff from ARC's high school clinics. Satellite clinics provided health education and screening, case management for students identified as being at high risk, and community health promotion. UMSAPPP facilitated the development of an adolescent life curriculum for seventh and eighth grades, which eight middle schools adopted as an elective. In addition, the UMSAPPP staff were involved with institutionalizing a "wellness" program in the schools to promote student and staff responsibility for their own good health and a healthy environment in the schools. Project Phoenix also had a successful parent involvement component: in collaboration with Planned Parenthood, the project developed a parent-child communication curriculum — Kids Need to Know — which it presented to parents in 14 churches.

Los Angeles: Operation Bright Futures

Operation Bright Futures was a comprehensive and intensive program for high-risk

students at Hollenbeck Junior High School in East Los Angeles, a largely Chicano community. The program included family life education, career awareness activities, and cultural arts activities offered in an after-school program through collaboration with Plaza de la Raza — a community-based cultural organization. It also provided health education and services, through a collaboration with a community-based health clinic, Alta Med. Another component of the program, through a collaboration with California State University at Los Angeles, was mentoring. Mentors were college students, many of whom came from East Los Angeles, who took Bright Futures students to on-campus activities on weekends to expand their sense of future educational options and to encourage them to take academic courses in middle and high school to prepare for college. The project also formed a career center through which it invited successful Hispanic business people to speak to students about possible educational and work options.

Milwaukee: Middle School Adolescent Pregnancy Prevention

The major focus of Milwaukee's UMSAPPP project was on providing extensive staff development to enhance the middle grades human growth and development curriculum. Four major collaborating agencies, chosen because of a long history of effective collaborations with the school district — Family Services of Milwaukee, Planned Parenthood, United Community Center and the Urban League — developed intensive pregnancy prevention training and presented it to teams of 10 teachers, counselors, and administrators from 18 middle grades schools. The training consisted of three days of activities, at the end of which teams developed schoolwide building action plans — activities such as health fairs, parent-child communication workshops, sessions with school staff, and classroom presentations encouraging pregnancy prevention. A community-based agency collaborated on these plans. The ultimate goal of the building action plans, according to the project director, was "to foster ownership of the problem of teen pregnancy both schoolwide and on the part of all those who live and work with middle-school-aged children." Project staff were also involved in a new initiative of the Milwaukee Life Options Coalition, which received a $250,000 state grant to develop a resource center offering "one-stop health services."

Norfolk: Urban Middle School Adolescent Pregnancy Prevention Program

In 1986, Norfolk adopted a middle school organization and developmental approach, including an advisory system in which teacher-mentors met with groups of 20 students twice weekly. The initial effort of Norfolk's UMSAPPP project was an intensive teacher training program to enable these teacher-mentors to deal effectively and comfortably with sexuality education. This special training took place in collaboration with two institutions of higher education and provided six graduate credits for the teachers. Partially as a result of UMSAPPP activities, a family life curriculum became a mandatory component of the K-12 school curriculum in the spring of 1987, and staff development regarding sexuality education was expanded. Program staff also collaborated with other risk prevention efforts, notably a drug education program in a public housing project where many students lived. UMSAPPP staff considered such non-school-based efforts important in Norfolk, since,

as a small city, it has some of the problems rural areas face — notably that school is often not a central site in the community because of the distance between home and school. In response to this, the Norfolk project was also involved in an after-school program offering recreational and social activities in a central facility in a housing project. This effort facilitated regular contact with parents through a monthly dinner and discussion group.

Oakland: Life Connections

The major activity of Life Connections was the establishment of a comprehensive after-school program in one school. The program offered young people both structured and unstructured activities, and served as a drop-in facility for students. Life Connections aimed to provide sex education information, improve student access to health and social service agencies, increase students' ability to make healthy choices, and expand students' awareness of career and education opportunities. It placed a special emphasis on enhancing students' awareness of, and pride in, their cultural heritage, and on helping students to improve their community — especially given the negative images of the community often portrayed in the media. After-school activities included presentations on sexuality and related issues by staff from collaborating agencies, dramatic performances by community groups, homework help, rap sessions, a fashion show organized by students, and visits to a community clinic for health screenings and demonstrations of contraceptive methods. An evaluation of Life Connections showed that the program was effective: no pregnancies occurred among the students in the program; school attendance increased, and participants' grade point averages were one-half point higher than comparison students.

PART ONE

MAKING THE CASE

Chapter One

Why Adolescent Pregnancy Prevention In The Middle Grades?

No matter how much you say that sex at a young age is not correct behavior, some children are engaging in sexual activity. You just can't pretend it's not happening. — Middle school principal

Middle school is the right place to intervene. The teacher is still respected, and this is where students make choices that will affect their lives. — Middle school counselor

Although the U.S. teen birth rate declined overall from 1970 to 1986, it is considerably higher than rates in the majority of other developed countries.[1] Further, this decline ended in 1987 and 1988 with significant increases in the rate of births among 15–19-year-olds. Although the 1988 rate of 54 births per 1,000 is considerably lower than the 1970 rate of 68 per 1,000, it is the highest rate since 1975. Approximately one out of 12 babies born in 1988 were born to unmarried teenagers.[2]

Too-early pregnancy and parenting have many negative consequences for both the young parents and their children: increased likelihood of school failure, dropping out, low labor market participation, and poverty. Overall, 67 percent of teen mothers and their children live in poverty,[3] and only 2 percent of young women who become mothers as teens finish college.[4] These issues, combined with the factors described below, make it imperative that middle grades educators and youth workers assume responsibility for pregnancy prevention:

- Teen mothers are younger than in the past, and birth rates among the youngest teens have increased.
- Teens are sexually active at younger ages than in the past.
- Educators increasingly see the middle grades experience as a crucial cutoff time in determining a student's educational future.

Childbearing Trends Among Young Teens

Today's adolescent mothers are younger than was the case in previous decades, and in comparison with their counterparts in other developed countries, many U.S. teen mothers are extremely young.[5] Further, the birth rate among the youngest teens has increased. According to the most recent statistics, the sharpest increases in teen birth rates have

been among younger adolescents: the birth rate rose by 8 percent among teens under 15 between 1984 and 1988 and by 9 percent among 15–17-year-olds. Over the same period, it rose by 3 percent among 18–19-year-olds.[6] Girls under 15 in the United States are at least five times more likely to give birth than are young adolescents in any other developed country for which data are available.[7]

In actual numbers, girls under 15 account for few pregnancies: in 1985, there were approximately 30,000 pregnancies to teens aged 10–14, resulting in 10,000 births.[8] This means that 3 percent of the approximately one million pregnancies to teens 19 and under are to very young teens. However, Supreme Court decisions limiting access to abortion and the increasing numbers of states requiring parental consent for abortions to minors may especially affect young pregnant teens. Pregnant girls under 15 are more likely than older teens to terminate their pregnancies by abortion. In 1985, 55 percent of this population obtained abortions, compared with 45 percent of pregnant teens aged 15–17 and 38 percent of pregnant 18–19-year-olds.[9] And lastly, while there are relatively few births to girls under 15, babies born to young teens are at extremely high risk of low birth weight — one in seven — and many do not survive the first year. One-quarter of those babies who do survive are at high risk of being permanently disabled mentally or physically.[10]

A great many myths "explain" why very young girls become pregnant. A common view is that they intentionally become mothers to "fill a void in their lives" and "to have someone to love." Yet the 1988 National Survey of Family Growth shows that almost three-fourths of births to teens resulted from unintended pregnancies.[11] The vast majority of very young women do not want to become mothers before they are ready to assume the responsibility. Not only are most of the pregnancies occurring to these young teens unwanted, many of their initial sexual experiences are involuntary. Recent research indicates that 15 percent of girls are sexually abused before their sixteenth birthday.[12]

Sexual Activity Among Young Teens

Despite societal expectations that the rates of teen sexual activity would decrease in light of the "say no" media blitz and the threat of the AIDS epidemic, the proportion of teens who report that they have ever had sexual intercourse has been increasing steadily. In 1971, the first year that such data were collected, 32 percent of teen females aged 15–19 reported that they had had sex.[13] This figure rose to 47 percent in 1982 and to 53 percent in 1988.[14] For 15–17-year-old females, the rates increased from 33 percent to 38 percent between 1982 and 1988.[15] Among 15-year-olds, approximately one-third of boys[16] and one-quarter of girls[17] have had sexual intercourse.

The national surveys do not include youth under age 15; however, anecdotal reports from practitioners across the country confirm the impression that growing numbers of young people are becoming sexually active prior to the age of 15. In the 1988 National Survey of Family Growth, 11 percent of women who were aged 15–24 reported having had first intercourse by their 15th birthdays.[18] A national study of sexual activity among young people aged 10–14 produced estimates that 5 percent of girls and 17 percent of boys in this group have had sexual intercourse at least once. These proportions suggest that 400,000 girls and 1.5 million boys could be at risk of pregnancy or of creating a pregnancy.[19]

Furthermore, growing numbers of children are involved in sexual intercourse before they are fecund.[20] Thus, the rates of sexual activity could increase more than the pregnancy rates in this age group. Girls first menstruate at about 12.5 years, but they may not be able to become pregnant for a year. Boys become fecund at about 14, but they can have intercourse at much younger ages. All of them, meanwhile, are at extremely high risk of sexually transmitted diseases.

Rates of sexual activity are often higher and age at initiation earlier among disadvantaged populations. Nationally, the average age at sexual initiation for boys is 13–15, but in one study of inner-city youth, the average age was 12.[21] A 1988 study of teenagers seeking services from a New York City health clinic found that 22 percent of girls were sexually active by age 13.[22] In an evaluation of Teen Choice, a pregnancy prevention program operating at the time in seven New York City senior and junior high schools, the average age of initiation of sex was 11.8 for boys and 14.5 for girls.[23] In the three UMSAPPP cities where sexual activity was surveyed, more than 50 percent of all middle grades students surveyed indicated having initiated sexual activity.

The younger a girl is at first intercourse, the less likely she is to use effective contraception or any contraception. In one study, only 31 percent of girls who initiated sexual activity before age 15 used any method of birth control. Of those aged 15–17 at first intercourse, 52 percent used contraception at first intercourse.[24] Further, girls who initiate coitus prior to age 15 wait longer than older girls to ever use contraception. In one study of clinic patients, those who first had intercourse before age 13 waited an average of 40 months before going to the clinic, whereas 18–19-year-olds waited 6 months.[25] For boys, the same is true: the younger the age at first intercourse, the less likely the use of contraception. According to a study based on data from the National Survey of Adolescent Males, 62 percent of young men use contraception at first intercourse: 84 percent of teens aged 18–19; 68 percent of those aged 15–17; 52 percent of those aged 12–14; and 25 percent of those under 12.[26] Needless to say, the risk of pregnancy is high among teens who do not use contraception. In one survey of metropolitan-area 15–19-year-olds, 25 percent of those who never used contraception conceived within six months of first intercourse, compared to 5 percent of those who always used contraception.[27]

One negative consequence of too-early unprotected intercourse that has spurred concern is the increase of sexually transmitted diseases among young people — specifically their risk of contracting AIDS. An estimated one in four students will contract a sexually transmitted disease before they leave high school.[28] One-fifth of the people with AIDS are aged 20–30,[29] and given the incubation period of 5–7 years, it is likely that many of them contracted the disease when they were in their teens. Fortunately, condom use among sexually active males has increased dramatically in the past 10 years. Among sexually active metropolitan-area males, the use of condoms more than doubled between 1979 and 1988. In 1988, 54 percent of sexually active males aged 12–19 reported having used a condom at first intercourse compared with 20 percent in 1979. However, despite the overall increase in condom usage for all ages, rates are still quite low for young teens: only 12 percent of sexually active boys under 12 and 36 percent of those aged 12–14 used a condom at first

intercourse, compared with 62 percent of those aged 15–17 and 75 percent of those aged 18–19.[30]

In summary, about 5 percent of middle grades girls and 17 percent of middle grades boys are engaged in sexual activity. Early initiation is associated with low levels of knowledge about reproductive risk, non-use of birth control at the time of first intercourse, and a long delay in obtaining birth control. All of these factors place sexually active girls and boys aged 14 and under at risk of becoming pregnant — or causing a pregnancy — and of contacting a sexually transmitted disease.

The Middle Grades: A Critical Juncture

> Young adolescents today make fateful choices, fateful for them and for our nation. The period of life from ages 10–15 represents for many young people their last best chance to choose a path toward productive and fulfilling lives. . . .[31]

> Teens, particularly younger teens, are participating in more risk-taking behaviors and are more troubled than teens ten to twenty years ago.[32]

Adolescence is a time of great physical, emotional and social growth, and typically a time when risk-taking begins. While some behaviors are both "developmentally adaptive, growth enhancing and essential for future adult functioning,"[33] other behaviors have great potential for harm and negative long-term consequences. Young people today face risks that were "almost unknown to their parents or grandparents, and face those risks at an earlier age."[34] Evidence is amassing that young people are engaging in risk behaviors — smoking, drinking, taking drugs and having unprotected intercourse — at far earlier ages than in the past, when teens typically experimented with cigarettes and alcohol in high school. Today, such experimenting often begins in the middle grades years, on average in the seventh grade.[35] In a study of the high school graduating class of 1987, 56 percent of students reported that they had begun drinking in grades 6–9, and 36 percent had begun drinking in grades 10–12. For smoking, 51 percent reported having started in the middle grades.[36] Among the 17 million children aged 10–14 in the United States, the probabilities are that:

- More than one in four will be poor.
- Twenty-eight percent will be at least one grade behind their modal grade in school or have already dropped out.
- One in four will attend public schools in central cities.
- Five percent of girls and 17 percent of boys will have had sexual intercourse. Only one-third of sexually active girls will use contraception.
- Eight percent of sexually active girls will become pregnant during a year.
- Twelve percent will be smokers and 3 percent will be heavy smokers.
- Seventeen percent will be drinkers and 4 percent will be heavy drinkers.
- One in four males will be involved in some form of delinquent behavior.[37]

While the prevalence rates of high-risk behaviors among middle grades children may not seem as significant as those among older youth, "the foundation for this pattern of behavior is set in early adolescence."[38] And these rates are almost certainly higher among urban, economically disadvantaged youth who live in families under stress and in communities ravaged by poverty, joblessness, crime, and drugs. Such communities have few — if any — recreational, cultural, sports, and tutorial programs to support students and occupy them in the long hours after school. In the words of one youth worker, "For many young people in these communities, sex and drugs have become the major recreational activities."

Further, many risk behaviors apparently are interrelated: "Problem behavior theory suggests a syndrome of acting out in school, early substance abuse, truancy, delinquency and early intercourse."[39] Early initiation of any one of these behaviors appears to predict the others, although the order of events varies among individuals and is different for males and females. Equally important, given the proportion of middle grades students who are behind their modal grade, school failure is the "precipitating event."[40]

An analysis of data on the 28 million young people aged 10–17 suggests that approximately 7 million, or one in four, are experiencing multiple difficulties: failing in school, using hard drugs, drinking excessively, and experiencing trouble with the law. This group encompasses many of the boys and girls who are unintentionally becoming teenage parents at very early ages. Another 25 percent experiment with these behaviors but avoid the negative consequences; half of all children probably will not try any of these behaviors until they are older.[41]

Intellectual Risks of Early Adolescence

Middle grades students are not at risk just in terms of their health and social development. Increasing evidence suggests that they are also at risk in terms of their intellectual development. According to the 1985 National Assessment of Educational Progress, 40 percent of all 13-year-olds have serious reading problems, and 25 percent of all seventh and eighth graders may not have the basic arithmetic skills to do everyday tasks.[42] Even more alarming, only 11 percent of these 13–year-olds are "adept" readers — that is, able to understand "relatively complicated written information." And only 20 percent of eighth graders write adequate essays. The assessment concluded that "students at all grade levels are deficient in higher order thinking skills."[43]

These figures are troubling, given research findings indicating that the "aptitude for critical thinking and for competent decision making is achieved or achievable by early to middle adolescence."[44] These competencies must be developed by education that engrosses young people and fosters critical habits of mind. Such programming is often in stark contrast to the "distressingly remedial" environment of many urban middle schools, where educators, "based on misguided views about the nature of cognitive growth . . . have moved toward withholding challenging instruction from early adolescents."[45] All too often, middle grades curricula assume the need for an intellectual moratorium while adolescents go through a period of unprecedented rapid physical and emotional growth.[46]

The Middle Grades and Dropping Out of School

> Although kids may not drop out of school until they're sixteen, they drop out psychologically in middle school.[47]

The dropout rate for middle grades students is very low: in 1985, only 2 percent of all 14 and 15-year-olds were officially counted as dropouts.[48] However, as described previously, 28 percent of these students are one year behind their modal grade, and grade retention is a strong predictor of dropping out. Further, rates of retention are far higher among minority youth than among white youth. For example, 44 percent of Hispanic and 39 percent of African American 13-year-olds are a year behind in school, compared with 26 percent of white youth.[49]

Some research has revealed that many students drop out before they reach grade 10. A study of Hispanic dropouts aged 14–25 concluded that 59 percent of them had not completed the 10th grade at the time of departure.[50] And in Washington, DC, more than half of all students who drop out do so before completing the tenth grade.[51] Discussion with educators reveals that while students may not actually drop out until later, it is in the middle grades that many students who eventually drop out "lose interest in learning and give up school for good."[52]

Teen Pregnancy, Parenthood, and Dropping Out of School

Too-early pregnancy and parenthood often have a negative impact on the educational status of the young mother. Teenage mothers complete fewer years of schooling and are less likely to graduate than their peers who delay childbearing.[53] Only one in five adolescent mothers who are not high school graduates finish their secondary education without delay.[54] While many young women who give birth as teenagers eventually receive their high school diploma, as many as one third of all the young women who become parents as teens will not have received their diploma or equivalency by the time their first child enters high school.[55]

Additionally, younger teen mothers are less likely than older ones to complete high school. Of the teens who gave birth in 1986, 38 percent of all 19-year-olds, 54 percent of all 18-year-olds and 84 percent of all 17-year-olds had not completed high school.[56] In a survey of women aged 20–26 who had had their first child as teens, only 45 percent of those who had given birth before age 15 had received their high school diploma or equivalency compared with 77 percent of those who had been 19 and 90 percent of those who had been 20 or older.[57]

However, while the conventional wisdom is that teen pregnancy and parenthood *cause* lower levels of academic achievement among this population, a very persuasive case can be made — and has been made in numerous places — that teen pregnancy is instead *a sign of school alienation*. In fact, many young women — as many as half of all teen mothers — become pregnant *after* they drop out of school.[58]

In brief, young mothers are poor and doing poorly in school. When analyses take into account differences in family income and academic skills, minority teens appear no more likely than white ones to be mothers. African American, white, or Hispanic, 20 percent of

young women from families with below-poverty incomes and who have poor academic skills are mothers, compared with 3–5 percent of those who come from above-poverty income families and who have solid academic skills.[59]

What Proportion of the Dropout Population Are Young Mothers?

It is difficult to ascertain what proportion of female dropouts are pregnant or parenting students. This is partially because many young women who are pregnant never formally withdraw from school or give another reason when they do. In addition, a sizable number of teens drop out of school before they conceive. In the High School and Beyond survey, 23 percent of female dropouts said that pregnancy was the reason for their leaving school.[60] However, various studies and surveys indicate that closer to one half of all women who have left school before graduation are pregnant or parenting.[61] Therefore, roughly one-quarter of all dropouts are pregnant or parenting young women.

Conclusion

Young adolescents are increasingly vulnerable to high-risk behaviors that may have negative long-term consequences. The incidences of such behaviors overlap, and young people who live in inner-city communities where few supports encourage their staying in school are especially vulnerable. Further, the connection between school achievement and risk behaviors is becoming clear. Therefore, educators and staff in youth-serving organizations must address the need for pregnancy and other risk prevention programming in the middle grades.

WHY ARE U.S. TEEN PREGNANCY RATES SO HIGH?

A 1985 Alan Guttmacher Institute study examined teen pregnancy rates in 37 industrialized countries and compared the rate in the United States with five countries judged to be similar in cultural background and economic development (England and Wales, France, Sweden, the Netherlands and Canada). The U.S. teen pregnancy rate emerged as more than double that of the closest country, with 96 pregnancies per 1,000 among teens aged 15–19, compared with 45 per 1,000 in England and Wales and 14 per 1,000 in the Netherlands. Even among white teens aged 15–19, the U.S. pregnancy rate was much higher — 83 per 1000.[62]

The study highlighted several major differences to help explain the high pregnancy rates among U.S. teens. One was the role that governments had assumed in helping young people avoid the negative consequences of sexual activity. In the five comparison countries, policymakers viewed adolescent pregnancy — not adolescent sexuality — as the major problem, and the governments had made a "concerted public effort to help sexually active young people avoid unintended pregnancy."[63] A similar effort was notably lacking in the United States, where the major government role has been in encouraging teens to say no. Teens in the comparison countries were much more likely than U.S. teens to receive free or low cost birth control from private physicians and public health clinics. Public policy in these countries was based on and itself bolstered a belief that young people could act responsibly if given a chance.

The Guttmacher study also noted the mixed messages that young people receive in this country about sex and contraception. Sex is everywhere but it is rarely discussed openly. The media often present sex as a commodity to be used "in fair exchange for other valuable goods such as love, respect, security and status."[64] Rarely, however, do they present it in a way that encourages responsible behavior:

> Movies, music, radio and TV tell them [young people] that sex is romantic, exciting, titillating; premarital sex and cohabitation are visible ways of life among the adults they see and hear about; their own parents are likely to be divorced or separated but involved in sexual relationships. Yet, at the same time, young people get the message that good girls should say no. Almost nothing that they see or hear about sex informs them about contraception or the importance of avoiding pregnancy.[65]

Another study concluded that because of these mixed messages

> many American teenagers are beset by confusion as to the proper norms governing their sexual behavior. The resulting ambivalence permits adolescent women to be swept away by sexual passion, but not to admit that passion leads to coitus or that coitus — if unprotected — leads to pregnancy.[66]

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Chapter Two

Early Adolescent Development And The Implications For Risk-Prevention Strategies

> Young adolescents face a daunting set of developmental challenges: the biological changes of puberty. . . ; the handling of feelings of sexual arousal. . . ; the move toward greater psychological and physical separation from parents; the assumption of new social roles . . .; the emergence from concrete thought to higher-level reasoning; the formulation of a clear and consolidated sense of self. . .[1]

It is axiomatic that early adolescence is a time of great and rapid change. As the chart in this chapter illustrates, during the middle grades years, young people are experiencing changes on all fronts — physical, intellectual, emotional, and social. Physically, early adolescents are going through more rapid growth than at any other period since infancy. Intellectually, they are moving from concrete thinking — centered on immediate experience — to formal operational thinking — being able to think abstractly. Emotionally and socially, early and middle adolescents are beginning to move away from the family as the chief center of emotional stability; relationships with peers and caring adults outside of family become very important.

To complicate matters, these changes occur at very different rates within one young person: "A physically mature 12-year-old may look like a 16-year-old, often act like a nine-year-old, and have thinking and reasoning skills that vary widely from task to task."[2] Furthermore, the process varies greatly from child to child. Consequently, within any group of early adolescents, levels of maturity and development differ widely. Given all these factors, it is no surprise that early adolescents are often a bundle of contradictory needs and impulses:

> Young people are maturing and interested in everything, yet also very immature; they can be respectful and utterly rude; they are confused one minute, yet cocky and self-assured the next; they can love you and hate you simultaneously; they are highly idealistic, yet totally out for themselves; they are struggling to be independent, yet at times totally dependent.[3]

Implications for Pregnancy Prevention Strategies

The nature of early adolescence has particular implications for pregnancy prevention. Young adolescents are typically very egocentric, convinced that "no one has ever felt like this before." Coupled with an imperfect ability to understand the consequences of their actions, this feeling can give young adolescents a sense of invulnerability: "It can't happen to me" and "I don't hang out with that sort of crowd" are typical expressions of this feeling. In addition, their strong needs for peer approval and "to be one of the crowd" makes young adolescents subject to peer pressure to engage in risk behaviors. Despite initial reluctance to engage in such behaviors, many teens will argue that "if everybody's doing it, it must be all right." Added to this, many young people — approximately one in five — report various forms of depression[4] often related to overwhelming family problems like substance abuse, child abuse and neglect, and homelessness. Such depression can engender passivity — a feeling that "nothing I do will make any difference."

Pregnancy prevention efforts must help young adolescents to understand the possible negative consequences of too-early and unprotected intercourse, in terms of their health, education, and future options. Interventions must do this in ways that are age-appropriate and that do not make unrealistic assumptions about what young teens can be expected to understand and do. As a doctor working in an adolescent health program said, "We think because adolescents look like adults that they can think and act like one."[5] Above all, practitioners warn, this age group will not respond to "scare tactics":

> It is important to remain upbeat and to treat sex as a normal, healthy part of life at an appropriate age. You have to convince young people that there is something they can do to avoid the negative consequences of sex. — Guidance counselor

What Do Young Adolescents Need?

To make a successful transition to adulthood, all adolescents have certain basic needs. They need to have opportunities to develop a sense of competence, to make real decisions and to have their opinions valued. They need opportunities to participate in projects with tangible outcomes, to know that they can make a positive contribution, and to receive recognition for their accomplishments. They need the support of caring adults to guide them in the face of sometimes overwhelming challenges. They need to be valued members of constructive peer groups, and they need to believe in a promising future with real opportunities.[6]

A review of prevention programs across the country that target high-risk youth, found that the most effective programs, regardless of their mission, have certain common elements. In addition to problem-focused curricula or services, effective programming offers youth contact with a caring, responsible adult; creates positive peer groups; provides opportunities for young people to develop their reading, writing, and math skills; supports the young person as an individual and as a member of a family and community; includes individualized educational and service components to reflect the needs of particular subgroups; offers opportunities for youth leadership; and provides opportunities for youth to contribute to their community.[7]

What an Effective Pregnancy Prevention Program Would Offer

Given an understanding of early adolescent development and the lessons learned from the family planning and the sex education movements, programming with a life options approach — of expanding adolescents' capacity to avoid risk behaviors and increasing their motivation to do so (as described in the introduction) — will prove the most effective in helping young people make a successful transition to adulthood. The following strategies are based on the kinds of programming some schools and youth-serving programs are offering young people across the country.

Strategies to Increase Student Capacity to Avoid Risk Behaviors

- Comprehensive K–12 health education covering human sexuality, reproduction, sexually transmitted diseases, family planning, treatment for minor illnesses and accidents, and provision of medications
- Education and training in social skills and values, including responsible decision making, self-esteem, assertiveness training, dealing with peer pressure
- Counseling about contraception and provision of contraception in school-based health centers, where permitted, or referral to community agencies
- Follow-up of sexually active students to ensure consistent use of contraception
- Counseling for sexuality, substance abuse, family problems, peer relationships, sexual abuse, and mental health
- Family life group sessions to promote nutrition, social skills, self-esteem, assertiveness training, accident prevention, and suicide prevention

Strategies for Promoting Student Motivation to Avoid Risk Behaviors

- Tutorial work to enhance basic skills and overall academic achievement
- Mental health counseling and treatment
- Substance abuse counseling and treatment
- Recreation and cultural activities, such as sports, field trips, and cultural performances
- Career education, including workshops in career planning, job skills training, and part-time job placements; programs to enhance teens' views of their life options and of the world of work; and programs to improve their employability skills
- Community interaction through students' volunteer work in the community and through community volunteers in the schools
- A mentoring/role model component to ensure contact with one caring adult offering support and modeling appropriate behavior

- Parent involvement activities, such as classes, discussion groups, and individual counseling; home visits by program staff; literacy projects; and volunteer projects at programs sites and schools
- Summer activities that allow adolescents to try new roles, develop new skills, and maintain skills learned during the school year

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What's Happening to Young Adolescents: Growth and Development in Early and Mid-Adolescence

Early Adolescence (Begins at age 10 or 11 and merges with mid-adolescence at age 14 or 15)	Mid-Adolescence (Begins at age 14 or 15 and merges with late adolescence at about age 17)
Physically Most rapid growth since infancy: girls' growth begins and peaks earlier than boys'; reproductive system developing; secondary sex characteristics begin to develop	**Physically** Growth slowing, stature reaches 95 percent of adult height; Secondary sex characteristics well advanced
Intellectually Beginning to move from concrete thinking (what is) to abstract thinking ("formal operation" — what might be true if ___); can't always perceive long-range implications of current decisions; expanded interests; intense short-term enthusiasm	**Intellectually** Growing competence in abstract thinking; Capable of perceiving future implications of current acts and decisions, but not always applied; reverts to concrete thinking under stress
Socially and Emotionally	**Socially and Emotionally**
Self Preoccupation with rapid body change; self-absorption, self consciousness; diminished self-esteem	**Self** Re-establishing body images as growth slows; preoccupation with fantasy and idealism as abstract thinking and sense of future develops
Family Redefining relationship with family, moving toward more independence while still looking to family for guidance and values; few major conflicts over parental control	**Family** Major conflict over control (rules, homework, curfew); struggle for emancipation, greater autonomy
Peers Increasing importance; seeking to become part of group to hide insecurities from rapid changes; comparing own normality and acceptance with same-sex peers; moving toward more intimate sharing of feelings	**Peers** Strong identification with chosen peer to affirm self-image; looking to peers for behavioral codes
Sexuality Defining self in terms of maleness and femaleness; learning how to relate to opposite sex (what to say and how to behave)	**Sexuality** Testing ability to attract and parameters of masculinity and femininity; developing sexual codes of behavior, personal value system
	Source: Adapted from material of Robert L. Johnson, M.D., associate professor of Pediatrics and director of Adolescent Medicine at the University of Medicine and Dentistry of New Jersey; New Jersey Medical School.

From Adolescent Pregnancy Prevention Clearinghouse, *Opportunities for Prevention: Building After-School and Summer Programs for Young Adolescents* (Washington, D.C. Children's Defense Fund, 1987). Reprinted with permission from the Children's Defense Fund.

Chapter Three

Middle Grades Education: Changing To Meet Developmental Needs

A volatile mismatch exists between the organization and curriculum of middle grade schools, and the intellectual, emotional and interpersonal needs of young adolescents.[1]

A concern with middle grades education has paralleled the concern about teenagers' pregnancy rates and increased sexual activity and risk-taking behavior, described in chapter 1, and the emerging research about the special needs of young adolescents, described in chapter 2. The work of the Center for Early Adolescence in the early 1980s focused the attention of educators, parents, and service providers on the needs of young people aged 10-15. By 1989, a series of studies of middle grades schools culminated in the Carnegie study *Turning Points: Preparing American Youth for the 21st Century*, which focused on the ineffectiveness of their structure, curriculum, and practices, especially for young adolescents considered at high risk of dropping out.

The majority of schools spanning sixth through ninth grades are organized like high schools in terms of size, curricula, and scheduling. They do not address the complex academic and behavioral needs of early adolescents or provide them with the kinds of consistent and caring supports — both with peers and with adults — that they need to navigate these difficult years. Students from disadvantaged communities and homes, many of whom are at high risk of school failure, particularly need such supports.

One practice characteristic of middle grades schools that increasingly appears developmentally inappropriate is departmentalized teaching — the assignment of different teachers to different subjects. While this may guarantee appropriate instruction, it can also mean a "dilution of supervision and support critical for adolescents who are undergoing rapid physical and psychological development."[2] It often means a rigid scheduling and regimentation of activities that preclude the kind of staff flexibility needed to provide the variety of learning experiences that an increasingly diverse student body demands.[3] Departmentalized teaching also denies young people the one-to-one contact with adults that is crucial at this age.

Another practice present in virtually all middle grades schools that has come under scrutiny is that of "tracking" — grouping students according to their achievement level in particular subjects. Like departmentalized teaching, in theory, this strategy ensures

appropriate instruction, enabling teachers to adjust instruction to students' skills level. In practice, it has proven to be extremely damaging to students in the lower tracks, who are often locked into "dull, repetitive programs leading at best to minimal competencies," and a "psychic numbing" from a "dumbed-down" curriculum.[4] Tracking also contributes to a division between minority youth — who are disproportionately placed in lower academic groups — and whites, thus helping to perpetuate racial stereotypes.

These concerns about middle grades education have given rise to reform efforts that seek to make the middle grades more relevant and captivating for students in general — even those not considered at risk. Reform efforts seek to restructure the middle grades and integrate into them a range of comprehensive services that provide adolescents with the high content and high supports they need to realize their academic and developmental potential. These efforts recognize, in the words of one teacher, that "middle schools are not just mini-high schools and that middle school students are not just mini-adults."

What Kinds of Middle Grade Schools Are Needed?

Middle grades restructuring has been the subject of detailed studies, notably *Turning Points* and Joan Lipsitz' *Successful Schools for Young Adolescents*. In brief, the Carnegie report recommended that each middle grades school become a "community for learning" by

- Creating smaller learning environments — schools within schools or houses where teaching is less fragmented, in terms of both scheduling and curriculum, than is typical in most middle grades schools
- Supplying young people with numerous supports in the form of stable and consistent relationships with their peers and with a small number of adults, specifically, by giving each student one adult advisor
- Providing students with a range of services, activities, and supports, both academic and nonacademic, that foster self-esteem and cooperative learning, enhance decision making, and give students a sense of future educational and employment options[5]

Above all, education for young adolescents must be active, taking advantage of young people's eagerness for participation:

> Active learning techniques include "thoughtful" classrooms in which students are encouraged to ask questions and challenge accepted wisdom. Group activities can include giving students opportunities to share their reasoning with others [and] projects that encourage students to apply and integrate knowledge and skills.[6]

Cooperative and group learning seems particularly appropriate for middle grades students, given the importance of the peer group at this stage. According to the Carnegie Council on Adolescent Development, such learning may be more effective than traditional classroom teaching techniques in fostering higher-order thinking skills, a sense of academic competence and respect for peers from diverse cultures. Cross-age tutoring is another appropriate teaching method for young adolescents and has a positive impact on academic

achievement for both the tutor and the tutee. Further, strong evidence suggests that students of all ability levels can be effective tutors.[7]

Putting it Together: Pregnancy Prevention and Middle Grades Reform

> Girls who can think, compute, read, and write know how to say no — or to take precautions — because they have visions of bright futures. — UMSAPPP project director

The connection between school achievement, too-early pregnancy and parenthood, and dropping out of school has been the subject of much comment. In its 1987 report on adolescent sexuality, the National Research Council concluded that teen choices regarding sexuality, pregnancy, and childbearing were partially related to their sense of future employment options:

> For too many high-risk teenagers, there are too few disincentives to early childbearing. Inadequate basic skills, poor employment prospects and the lack of successful role models for overcoming the overwhelmingly negative odds of intergenerational poverty have stifled the motivation of many . . . to delay pregnancy.[8]

Given this connection, it seems apparent that pregnancy prevention programming taking a life options approach must go hand in hand with efforts to make the middle grades more responsive to the needs of early adolescents, especially those at highest risk. On the one hand, "putting young people on the achievement track" — as one researcher expressed it — motivates them to avoid behaviors with possible negative long-term consequences; on the other hand, providing specific pregnancy prevention programming, as described in Part 2, increases young people's capacity to avoid such behaviors. Indeed, implementing programs that take a life options approach can bring about a focus on the developmental needs of young adolescents and be a catalyst for school restructuring. This happened at one UMSAPPP school, as described in the introduction.

It also happened at Intermediate School 52 in New York City, where the Center for Population and Family Health of Columbia University established a school-based clinic in 1985 (see chapter 10). School restructuring activities were undertaken when clinic workers identified what they saw as a major problem affecting the student's well-being: their poor academic skills. Initially an after-school program was developed, but this served only a small number of students and had only a limited impact on the improvement of instruction throughout the school. Restructuring activities were initiated that culminated in the development and implementation of a school restructuring plan with the following components: organization of the school into smaller units; extensive staff development on middle grades organization and instruction appropriate for early adolescents; and the election of a school-based management team.

Resources

Adolescent Pregnancy Prevention Clearinghouse. *Making the Middle Grades Work.* Washington, DC: Children's Defense Fund, 1988.

A review of middle grades education, state reform efforts, and exemplary middle grades programs.

Carnegie Council on Adolescent Development. *Turning Points: Preparing American Youth for the 21st Century.* New York: Carnegie Corporation, 1989.

The report of the Task Force on Education of Young Adolescents; summarizes the state of middle grades education and recommends major changes.

Center for Human Resources, Heller Graduate School. *Future Options Education: "Not Another Handbook" Handbook on How to Help Young People in the Middle Grades Aspire and Achieve.* Waltham, MA: Brandeis University, 1990.

Outlines many strategies for improving middle grades education and describes effective programs.

Dorman, Gayle. *Improving Middle Grades School: A Framework for Action.* Carrboro, NC: Center for Early Adolescence, 1987.

Describes the Middle Grades Assessment Program and documents its impact in middle schools. Offers many suggestions for developing and implementing school improvement activities and sets forth a framework for identifying and examining successful middle schools.

High Strides: The Bimonthly Report on Urban Middle Grades. Washington, DC: Educational Writers Association.

Covers middle grades reform issues and highlights effective middle grades schools and programs.

Lipsitz, Joan. *Successful Schools for Young Adolescents.* New Brunswick, NJ: Transaction Books, 1984.

A study of four schools that meet the developmental needs of young adolescents and help them succeed academically.

Urban Middle Level Initiatives, National Middle Schools Association, 4807 Evanswood Drive, Columbus, OH 43229-6292

A task force to conduct an extensive study of middle-level urban education and develop a model of an effective urban middle level school.

Notes

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2. Adolescent Pregnancy Prevention Clearinghouse, *Making the Middle Grades Work* (Washington, DC: Children's Defense Fund, 1988).
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7. "Big Kids Teach Little Kids: What We Know About Cross-Age Tutoring," *Harvard Education Letter* (Vol. III, No. 2, March 1987).
8. "Risking the Future: A Symposium on the National Academy of Sciences Report on Teenage Pregnancy," *Family Planning Perspectives* (Vol. 19, No. 3, May/June 1987).

Chapter Four

Six Essential Elements Of An Effective Pregnancy Prevention Program

Six important characteristics of effective pregnancy and risk prevention programming emerge from the experience of UMSAPPP and of other programs across the country:

- An effective program must empower teens.
- An effective program must appeal to males.
- An effective program must deal with contraception.
- An effective program must respond to diversity.
- An effective program must involve families.
- An effective program must be multifaceted.

Empowering Teens

> Young people have ideas, even if they are sometimes expressed in ways that have to be decoded. Adults must be willing to listen to and trust young people to make responsible decisions and to behave responsibly if given real-life situations and supports. — Director of youth serving agency

Any program seeking to help teens must be participatory: it must seek ways to involve teens actively, "empowering" them by giving them a sense that they can make a difference in their own lives and in the world. Programs can do this by providing teens with opportunities to express their ideas, to plan and implement activities that they deem necessary, and to receive recognition for their achievements. Across the country, a number of organizations have started identifying, describing, and developing activities that empower youth, and many risk prevention programs are including such strategies in their curricula. In contrast to the concern with youth culture that emerged in the sixties and early seventies, which was based largely on a negative view of youth as a deviant population with questionable values and volatile behavior, the emerging youth empowerment movement is based on a positive sense of young people and of their potential to make a positive contribution to society. More important, interest in youth empowerment has arisen as the need to construct an identity based in part on feeling competent, effective and connected — to both the

community and the larger society — has emerged as a primary developmental task of adolescence.

Numerous activities, if properly carried out, can affect the process of teen empowerment: service learning activities; involving teens in planning and participating in events such as health fairs, AIDS marches, making videos on relevant health issues; having teens present certain aspects of a curriculum, or serve as mentors and counselors; training teens as advocates on youth issues and providing opportunities for them to discuss important issues at teen forums or speak-outs; making small grants available and letting teens decide on what kinds of projects or activities the funds are to be spent. Having such opportunities to develop a sense of competence is important for all teens. It is especially important for economically disadvantaged youth, who often come from communities where models of positive connection to the larger society and opportunities for developing a sense of competence are few. Further, such youth may have activities available to them in their communities, like gangs, that meet some of their developmental needs in the short term but ultimately are destructive.

Whatever the specific strategy, it is important that empowerment activities for youth be age-appropriate. Participating in an age-appropriate community service activity can increase a young person's sense of competence and increase his or her feeling of connection to the community. On the other hand, a developmentally inappropriate community service activity might have a very negative impact on the young person's sense of competence. Any empowerment strategy should also provide opportunities for reflection and group discussion. This is developmentally appropriate, given how important the peer group is and how much teens listen to and learn from other teens.

A significant challenge inherent in a youth empowerment strategy is the adult mistrust of youth so dominant in our culture. Not only are some youth not valued, but many are the objects of much mistrust stemming from racial and class differences. This mistrust is partly rooted in changing social mores, and the propensity of youth to respond readily to such change. Adults often base their view of youth culture on the pictures that the media, specifically MTV, present. In this negative light, the older generation sees young people — as it always has seen them — as undisciplined, irresponsible, lazy, and out for immediate gratification:

> People say to me, "What's wrong with kids today? They act so crazy!" I tell them, "Nothing's wrong with kids. They haven't changed. Don't you remember? We're the ones who have changed!" — Youth worker

The Medium Is the Message

In designing activities that empower youth, it is important to remember that, while the benefits to society — "keeping the kids off the street" and "getting the work done" — are desirable goals, they are secondary considerations. The primary goals are to give young people learning experiences that will enable them to feel valued members of society and to become effective advocates for themselves and other youth. In other words, older people must see youth not so much as resources but as agents of change. This means giving them

meaningful opportunities to participate in the process: to decide what activities to undertake, how to conduct them, and who is to do them.

The Youth Action Project in New York City's East Harlem involves young people in many decision-making capacities. The project was initiated to create a medium for young people to express their ideas, to have their opinions respected, and to have a role in planning and implementing community projects that they determined necessary. Participants have become involved in renovating abandoned buildings in response to the problem of homelessness in the community; setting policy regarding youth issues through a Youth Congress, which set an agenda for the nineties; and in advocating for youth issues, addressing public meetings and talking to officials. In so doing, the director of the program explained, "they have contradicted the image of youth as disorganized, disrespectful, and rowdy, and have shown that, if given the opportunity, young people want to and can make a difference.[1]

El Puente

The concept of empowerment is central to El Puente, a community-based multiservice youth program operating since 1983 in the Williamsburg section of Brooklyn, New York, serving a largely Hispanic population of young people and their families. *El Puente* means *bridge* in Spanish; this name refers to the nearby Williamsburg Bridge, and implies the hope that activities at El Puente will provide a bridge for young people both from adolescence to adulthood, and from dependency to self-empowerment. It is hoped they will also provide a bridge for various Hispanic groups in the community into the wider society.[2]

El Puente offers a variety of recreational and cultural activities in three basic areas: social medicine, arts, and social health. It provides a medical exam for every young person participating in the program; karate and aerobic classes; photography, fine arts, dance, theater, and music classes; counseling and legal services; GED and ESL classes; and job placement services. Providing multiple points of entry to the program dispels the stigma often attached to the use of special services. In fact, El Puente has done away with the notion of "problem youth." As the director of the program said: "You may have a problem, but you are not a problem kid."

Young people are actively engaged in many aspects of program planning, design, and implementation. They are trained as peer counselors — as PACE-Makers (Peer Advocacy, Counseling, and Empowerment-Makers) — and help with discussion groups and counseling. Young people teach music, dance, and aerobics, and they work as receptionists and maintenance workers. While services are free, the program expects that all young people involved will contribute to El Puente and to the community. Parents and other family members are encouraged to take part in program activities. El Puente has also trained parents as advocates for their children in the schools. Another vital aspect of El Puente is the recruitment of people from the community who have "made it" — as artists, doctors, lawyers, nurses — to return as visible role models for the young people.

Appealing to Males

> We have to speak a language that appeals to boys. — Director of pregnancy prevention program

While many pregnancy prevention programs have been directed to girls, it is now clear that successful pregnancy prevention activities must appeal to boys, as well. As with girls, dealing with boys entails understanding the pressures of gender roles and stereotypes on adolescents. Despite some changes in recent years, boys are still typically measured by their performance and competence, while girls are measured by their attractiveness and their personality: "Throughout childhood boys are encouraged to conform with their gender role of aggressiveness, athletic performance, dominance and competitiveness."[3]

In many cultural groups, boys are expected to express their sexual identity by acting out, "scoring," "doing it." As one UMSAPPP teen described it: "Some guys got to have a sexual resume!" Girls, on the other hand, are expected to suppress their sexuality by saying no. Many parents, whether consciously or not, foster this double standard by accepting sexual activity among their sons while condemning it among their daughters.[4] These pressures take a toll on boys and young men. Boys are seen in guidance clinics three times as often as girls; boys outnumber girls in mental institutions; and suicide, accident, and mortality rates are higher for young males than for females.[5]

Family communication about sexuality is more limited with boys than with girls. On the whole, mothers are more likely than fathers to discuss sex with their children, and more likely to discuss contraception with their daughters than with their sons. Some 46 percent of girls, compared with 25 percent of boys report having talked to their parents about birth control.[6] It is no surprise, then, that teenage boys are less knowledgeable about sexuality than girls. In a Search Institute survey of eighth graders, boys were disproportionately represented among young people who had never talked to any adult about sexuality.[7] Boys know less about contraception than girls even though they have had the same exposure to sex education.[8]

Much attention has focused on the finding that many urban schools do not educate African American males as effectively as they educate other students. Researchers have increasingly documented in school systems across the country that young African Americans, especially males, are disproportionately put in special education classes. The Urban League addressed this issue in a 1990 report, *Those of a Broader Vision: An African American Perspective on Teenage Pregnancy*, which describes urban schools as "particularly cold and unforgiving (hostile) to black males."[9] It urges educators and youth workers to be sensitive to this issue and to media images of African American males that promote "an image of physical rather than intellectual prowess, promoting violence rather than peaceful behavior."[10] Further, the report calls for policymakers and practitioners to address the dominant street culture that reinforces a "culture of male bravado, that is . . .dysfunctional in today's world . . . destructive of the intimate male and female bonds which are the basis of family life."[11]

Little research has examined what strategies are particularly effective with young men. Practitioners agree, however, that boys, as much as girls, need education about all

aspects of sexuality and contraception, and that they must understand the need for a shared responsibility for pregnancy prevention. Boys must be helped to communicate effectively with their families and with girls about sexuality, and they require positive male role models. One survey of programs geared to males concluded that males must be "offered opportunities for reasoning about sexual issues in nonthreatening situations."[12] Small group counseling sessions, peer education, and family life education courses that promote active reflection, such as the theory-based sex education course, described in chapter 6, seem to provide such opportunities. Above all, one practitioner advised, educators must be aware of the mixed messages that young men receive about sexuality:

> Boys get all sorts of messages that having sex will prove their masculinity. Then, when the baby arrives, we call them irresponsible, selfish, uncaring, out for immediate gratification, incapable of planning. We have to stop blaming boys and empower them to be responsible. — UMSAPPP project director

Dealing With Contraception

> I think in the middle grades school we can all agree to push for abstinence — but we have to be prepared for those that won't take our advice. — Middle grades teacher

As discussed in the box in chapter 1, mixed messages about sexuality often affect young teens' attitudes to birth control. Typically, birth control use is viewed somewhat suspiciously in this country — as proof that sex was planned. "I had sex, but I hadn't planned to" is a response with which a pregnant young woman might defend herself. In this view, getting pregnant is the result of uncontrollable passion — the teen was "swept away" as so often happens in films and on television.

These mixed messages and ambivalent attitudes affect the way in which family life/sex education courses treat birth control. Despite the growing support for pregnancy prevention in the middle grades, in practice, there is a gap between what teachers think should be taught and what is actually taught. While 97 percent of sex education teachers think that sex education classes should address where students can obtain contraception, only 48 percent are in schools where the curriculum does this. While 95 percent of teachers cover the transmission of AIDS in seventh grade, only 83 percent cover birth control methods; 63 percent cover "safe sex" practices, and 41 percent provide information on local sources of birth control.[13]

In many programs students receive information about birth control methods, sometimes including explanations of how to use particular methods. Some programs take students to clinics in the community. Emphasis on condoms has been growing, and practitioners speak of having to help young people overcome their initial reluctance to purchase and use them. What programs will teach about contraception and at what age depends on what they perceive that students need, but often also on a perception of what parents want and what the community will allow. Girls Incorporated has developed AIDS education curricula for three age groups. These could serve as guidelines for what is age-appropriate for pregnancy prevention programs as far as contraception is concerned. The objectives of the curricula are as follows:

Girls aged 9–11: The primary goals are to allay fears about AIDS — to assure young people that AIDS is not spread through casual contact; that it is difficult to contact AIDS; and, above all, that AIDS is preventable.

Girls aged 12–14: The primary goal is to set the groundwork for responsible decision making and the avoidance of high-risk behaviors.

Girls aged 15–18: The primary goal is to teach young women to protect themselves, both by reinforcing what they have already learned about contraception and by making linkages to community services. The curriculum includes specific information on condoms.

Clearly, depending on the population, the curriculum for 15–18-year-olds could be appropriate for 12–14-year-olds.

Regardless of what a particular program teaches about contraception, teachers often provide information informally and on a one-to-one basis.

> Well, we're not allowed to talk about birth control so I don't. Of course, the students have lots of questions, so I do have to answer them. And if they ask, I make referrals to the local clinic. Then I follow up students to make sure they keep their appointments. — Middle grades counselor

Gender Stereotypes and Contraception

Our attitudes about contraception not only are fairly ambivalent, they also are for the most part gender-stereotyped: that is, most people view contraception as the responsibility of the female, and this is true at all age ranges. Girls who get pregnant, then, are doubly to blame — both because they had sex and because they failed to protect themselves. In the age of AIDS, these attitudes are changing, but encouraging sexual responsibility will entail dealing with stereotypes regarding who is responsible for what. To be effective, programs must break down the stereotype that contraception is "girls' stuff." As one practitioner put it, "We have to make it manly to be responsible." Also, in some cultural groups, contraception is considered the prerogative of the male, and young women often feel it is unfeminine to bring it up. Young women must learn to be assertive about the use of contraception — and specifically, the use of condoms.

The curriculum, Positive Images: A New Approach to Contraceptive Education seeks to empower adolescents to be sexually responsible by creating a positive image of contraception and of those who use contraception. It includes sessions on high-risk behavior, parent-child communication, choices and consequences, and decision making — in general and particularly with regard to contraception and contraceptive behavior. The curriculum teaches male and female students in grades 8–11 strategies that help overcome the barriers to contraceptive use — guilt, embarrassment, misinformation, lack of comfort — and integrates birth control into the ideology of love, relationships and sexuality. It examines questions of who is responsible for decision making concerning contraception and sends out a very strong message that "swept away is not OK." It encourages students to examine negative attitudes to birth control and its use, and helps them to develop the comfort level and knowledge necessary to purchase contraceptives. The curriculum broadly defines sexuality

as more than just intercourse and suggests "outercourse" as a means of avoiding pregnancy.

Responding to Diversity

> Acknowledging, building respect for and celebrating diversity is one of my biggest challenges, especially with young adolescents, for whom the need to conform is great. — Family life education teacher

Increasingly, programs seeking to encourage young people to avoid risk-taking behaviors must deal with youth from different racial, ethnic, linguistic, religious, and socioeconomic backgrounds. Even within a school system or community that is fairly homogenous, language, religious, and cultural differences may be significant. Issues of diversity can arise in many components of risk prevention programs:

- In a family life education course, for example, practitioners may encounter differing attitudes to sexuality, marriage, the role of women, contraception, abortion, gender preference, sex before marriage, out-of-wedlock births, and single-parent families.
- In mentoring programs, differences of culture and class between mentor and mentee may be great — even in programs that match them by race and gender.
- In programs with service learning components, teens may encounter such differences in the workplace.
- In youth empowerment activities, some cultural groups and communities may differ with program staff about what sort of work is valuable and what activities are appropriate to encourage young people to do.

Practitioners advise that it is important to acknowledge such differences, to respect them, and to discuss them in a nonjudgmental way. Doing so can sometimes provide a valuable opportunity to discuss sensitive issues:

> Acknowledging differences can be a great opportunity to introduce new ideas. A lot of my students hold very traditional views about women. I don't lecture them about sexism. I talk to them about women — especially from their own culture — whom I know they respect and who are nontraditional in their lifestyles. — Family life education teacher

Above all, it is important for youth workers and educators to model the behavior they want young people to emulate:

> You can't expect kids to be tolerant if you're not tolerant. You can't expect them to respect diversity if you don't. — UMSAPPP staff member

Many family life/sex education curricula have units dealing with racism and sexism. These can provide good starting points for discussion. A number of materials are available in Spanish, and programs can adapt curricula to allow for the needs of a particular population. In the UMSAPPP Atlanta project, for example, staff regularly involved students in writing and performing "raps" to convey messages about sexuality and peer pressure.

Staff from community-based organizations can be an excellent resource for dealing with issues of diversity — either in presentations to students or in staff development sessions. Performances highlighting the culture of various racial and ethnic groups and involving youth in such performances was an important aspect of several UMSAPPP projects.

While family life education curricula often address racism and sexism, they infrequently cover gender preference. This is an issue that many practitioners, especially at the middle grades level, may be reluctant to speak about. However, while this question may be difficult to discuss, it is important that educators and youth workers do so — both because of AIDS and in order not to alienate the 10 percent of youths who are homosexual and the 17 percent who are experimenting with homosexuality[14] when they may most need support in coming to terms with their sexual identity. Practitioners must convey the attitude that homosexual behavior is normal even though some religions may consider it immoral. A discussion of gender preference can provide an opportunity to discuss the stereotypes of masculinity and femininity and to suggest that in the past, arbitrary lines have limited the range of human behavior. At the very least, young people must be discouraged from using derogatory words like "fag," "lezzie," and "dyke," just as they would be from using racist or sexist language.

Involving Families

> Involving parents gives an important message about openness and about respect for families. — UMSAPPP project director

While growing evidence suggests that involving parents and other family members in the schools can have a positive impact on student achievement, no evidence indicates that improved parent-child communication alone can have an affect on teen pregnancy rates. A 1990 study based on the 1982 National Survey of Family Growth concluded that family interaction is not associated with forestalling adolescent sexual activity, although it may have a positive influence on adolescent use of contraception and on teens' selection of abortion and adoption as alternatives to parenthood.[15] However, the work of the Search Institute indicates that family values can influence teen attitudes about sex. An analysis of data gathered during the field-testing of Human Sexuality: Values and Choices concluded that the two most powerful predictors of a teen's choosing to believe that "it would be against my values to have sex as a teenager" are perceived parent and peer values.[16] This research also showed that teens who consult an adult about sex overwhelmingly consult their parents. In one study, 72 percent of teens said they had consulted an adult about sex in the previous year, and the vast majority of these had talked to one of their parents.[17] Given this finding, and given the important message that parental involvement activities communicate, it is likely that many pregnancy prevention efforts will try to involve parents and families.

Parents as Sex Educators

One of the main ways in which parents can be involved in pregnancy prevention activ-

ities is as sex educators of their children. Many parents want and expect to be their children's primary sex educators. A 1988 study found that the majority of both parents indicated that they preferred and expected to be primarily responsible for their child's sexuality education, even though these parents had not received such instruction from their parents.[18] However, a gap often separates parents' desire to share information about sexuality with their children and their doing so. In one survey, 68 percent of teens reported having talked about sex with their parents; only half of these reported having talked about contraception.[19] Another study found that although parents had intended to talk with their child frankly about sexuality, few in fact had initiated conversations, and many were waiting for the child to bring up the topic. Those who had engaged their child in a discussion tended to view it as a one-time task, with little need for follow-up. This study concluded that parents experience the greatest comfort level in discussing anatomy and "plumbing-related" topics with their children, and much more difficulty discussing "value-laden" topics, such as sexual behavior, premarital sex, and homosexuality.[20]

Most parents — in one survey, 98 percent — report wanting help in discussing sexuality and related topics with their children.[21] Many are reluctant to talk to their children about sex, partially because of their lack of knowledge and partially because "they're embarrassed that their kids know more than they do." A number of parent-child communication curricula address this problem, and some family life education curricula have units geared specifically to parents. One study to identify effective strategies for improving parent-child communication regarding sexuality determined that the most consistently effective format was that in which parents and young adolescents received instruction first separately and then together.[22]

Other Ways of Involving Families

Families can be involved in pregnancy prevention programming in numerous other ways. Parents — both as individuals and in groups, such as the PTA — can participate in the planning of a program or of a specific set of activities, serving in an advisory capacity on boards or as part of the collaborative planning group. Parents can assist in the operation of the program by working as volunteers or as paid aides during specific activities. Parents can be ideal as outreach workers both in making home visits and in recruiting young people for the program. Parents can help create support for a program, by addressing hearings or speak-outs, or getting petitions signed. And where funds permit, parents can even receive a range of other supports — GED or ESL classes, counseling, employment training. The Children's Aid Society program (see chapter 13) provides such services to the families of its young people.

Family Involvement: A Major Goal of Collaboration

Getting parents and families involved should be one of the major goals of any collaboration on adolescent pregnancy prevention: "Parents can be the primary sex educators of their children, with schools, churches, synagogues, and community organizations as their partners in a lifelong process."[23] In involving families, community-based agencies often have

greater access than schools, and consequently schools must look to them to lead the way. As one community-based agency director said: "You have to take the program to parents. The parents who need it most are the ones least likely to attend events in schools." Results of an unpublished study showed that young people in housing projects with Boys and Girls Clubs engaged in fewer high-risk behaviors than young people in projects without such clubs. Further, adults in projects with clubs were more involved in schools, in juvenile social clubs, and with tenant associations.[24]

In Milwaukee's UMSAPPP project, when parent meetings took place in the evening at a public library in a neighborhood from which many students were bused to the middle school, attendance improved dramatically. In Kansas City, a series of family life and parent-child communication classes, offered by nurses and teachers involved in the UMSAPPP project in community churches, was very well attended.

Efforts to involve families in pregnancy prevention and the education of their children in general often encounter great barriers. Even activities offered under optimal situations — taking place at convenient times, providing child care, and focusing on issues of high interest to parents — face enormous impediments. Many families are under considerable stress and in many urban schools, a significant proportion of the children are in foster care. Some students do not want their parents involved, and practitioners must be sensitive to this. Practitioners also caution that lack of parental involvement does not mean that parents are unconcerned about their children:

> When parents come, it means they're interested; when they don't come, it doesn't mean they're not interested. There are many barriers to parents getting involved — some of them obvious and some of them not so obvious. The important thing is to keep trying, because trying to involve families shows them that we want their input. — UMSAPPP project director

Taking a Multifaceted Approach

> A tested educational curriculum . . . coupled with a secondary intervention strategy such as volunteer service, a positive older youth role model or a mentor for teen clients, holds promise for changing negative teen behavior.[25]

Experience suggests that no single prevention strategy will be as effective as a combination of strategies. Those discussed in part 2 of this handbook — family life education, school-based clinics, counseling, peer education, education helping young people postpone sexual involvement, service learning, and mentoring — seem, in some combination, to be the most promising and to best meet the needs of early adolescents. Some of the strategies focus specifically on sexuality — postponing sexual involvement and counseling, for example; other strategies — mentoring and service learning — do not. In combination, however, these approaches fulfill the two primary needs of effective pregnancy prevention: to increase both the capacity of young people to avoid too-early pregnancy and parenting and their motivation to do so.

Pregnancy prevention programming can be part of a school's curriculum, or it can be available to students — all students or those considered most at risk — in after-school pro-

grams. Ideally, pregnancy prevention activities can take place both in the regular school day and be enhanced by after-school and summer activities. And all these activities need not be school-based. Some — especially after-school activities — can take place in community-based agencies.

Not all the interventions this handbook discusses are equal in their proven effectiveness in preventing pregnancy or delaying sexual activity and encouraging contraception use. Pregnancy prevention activities are difficult to evaluate, especially at the middle grades level, as discussed in chapter 19. Some components of pregnancy prevention programs are especially difficult to examine because they rarely stand alone — mentoring is an example. However, it seems clear that effective pregnancy prevention requires a combination of activities that empower youth with the capacity and the motivation to avoid risk behaviors.

Resources

Empowerment

Mobilization for Youth Development, Academy for Educational Development, 1255 23 Street NW, Washington, DC 20037.

> A five-year initiative to facilitate an understanding of, acceptance of, and investment in community and educational supports promoting positive youth development and empowerment. Will produce publications, hold conferences, establish youth worker training centers and a multisite demonstration project.

RespecTeen Program, Lutheran Brotherhood, 122 West Franklin Avenue, suite 525, Minneapolis, MN 55404.

> A nationwide effort aimed at helping parents, adolescents, schools, youth-serving agencies, congregations, and communities work together to promote positive youth development. Has a number of resources available for communities and school districts, including a survey-based needs assessment, available for use by school districts and communities.

Males

Adolescent Pregnancy Prevention Clearinghouse. *What About the Boys? Teenage Pregnancy Prevention Strategies.* Washington, DC: Children's Defense Fund, 1988.

> A review of strategies specifically geared to boys.

Dryfoos, Joy G. *Putting the Boys in the Picture: A Review of Programs to Promote Sexual Responsibility Among Males.* Santa Cruz, CA: Network Publications, 1988.

> A review of the literature and of many programs and strategies geared to males; makes recommendations for including boys in pregnancy prevention activities more effectivfely.

Contraception

Brick, Peggy and Carolyn Cooperman. *Positive Images: A New Approach to Contraceptive Education*. Santa Cruz, CA: Network Publications, 1986.

A curriculum designed especially to create positive attitudes about contraception.

Diversity

Abbey, Nancy, Claire Brindis, and Manuel Casas. *Family Life Education in Multicultural Classrooms: Practical Guidelines*. Santa Cruz, CA: Network Publications, 1991.

Provides guidelines for responding effectively to the diversity of middle grades and high school students in family life education courses, contains sections for determining if a current curriculum is reflective of cultural diversity and provides four sample lessons that model culturally appropriate family life education approaches.

Adolescent Pregnancy Prevention Clearinghouse. *Latino Youths at a Crossroads*. Washington, DC: Children's Defense Fund, 1990.

An in-depth discussion of issues relevant to Latino youth.

Affiliate Development of Adolescent Pregnancy/Parenting Program. *Those of a Broader Vision: An African American Perspective on Teen Pregnancy*. New York: National Urban League, 1990.

An analysis of pregnancy prevention issues pertaining specifically to the African American community.

Center of Population Options. "Life Planning Education in Hispanic Communities." Washington, DC: Center for Population Options, 1988.

A supplement to *Life Planning Education: A Youth Development Program*. Discusses issues relevant to Hispanic youth and contains a resource list of materials pertaining to Hispanics and in Spanish.

Como Planear Mi Vida. Washington, DC: Center for Population Options, 1987.

A Spanish-language version of *Make a Life for Yourself*, a workbook to help teens set educational and vocational goals.

Forliti, John, Lucy Kapp, Sandy Naughton and Lynn Young. *Valores Y Decisiones*. Trans. Michael Curti. Minneapolis: Search Institute, 1989.

A 15-unit curriculum geared to seventh and eighth grade students. Contains units on the physical and emotional changes of puberty, making choices, dating and planning for the future. Abstinence is emphasized but one unit does describe methods of contraception.

Gray, Mattie Evans. *Images: A Workbook for Enhancing Self-Esteem and Promoting Career Preparation (Increasing Minority Aspirations through Gender Equity for Students)*. Sacramento, CA: The Circle Project, California State University, 1988.

A self-esteem enhancement and career awareness program, developed particularly for use with African American junior and senior high school girls. (Available from the California State Department of Education, Bureau of Publications, Sales Unit, P.O. Box 271, Sacramento, CA 95802-0271.)

Matiella, Ana Conseulo, ed. *The Latino Family Life Education Series*. Santa Cruz, CA Network Publications, 1988-90.

Family life education curriculum geared to Latino middle grades youth. Its four units are Cultural Pride, La Familia, La Comunicacion, and La Sexualidad. Each unit explores Latino history, traditions, and values as they affect attitudes about sexuality and related issues. Written in English, incorporating Spanish *dichos* (proverbs) into the text. Each unit can be used separately.

Involving Parents

Berla, Nancy, Anne Henderson and William Kerewsky. *The Middle School Years: A Parents' Handbook*. Columbia, MD: National Committee for Citizens in Education, 1989.

A guidebook for parents of middle grade students, offering strategies for helping students achieve academically, with special attention to single, working and non-English-speaking parents.

Brown, Jean G., Mary Downs, Lynn Peterson, and Carol Simpson. *Parent-Child Sex Education: A Training Module*. St. Joseph, MO: Family Guidance Center, 1978, updated 1989.

A curriculum to foster communication between mothers and daughters, and fathers and sons. Includes a description of how to set up a program in a community, class outlines and lecture materials, and directions for creating specific activities and games.

Forliti, John, Lucy Kapp, Sandy Naughton and Lynn Young. *Human Sexuality: Values and Choices: A Parent Guide*. Minneapolis: Search Institute, 1986.

Encourages parent-child communication, whether or not children have taken Search's *Human Sexuality: Values and Choices*.

Henderson, Anne. *The Evidence Continues to Grou: Parent Involvement Improves Student Achievement*. Columbia, MD: National Committee for Citizens in Education, 1987.

Summarizes 49 studies documenting the positive impact of parental involvement on student achievement.

Notes

1. Sonia Bu, Director, Youth Action Project (Presentation at UMSAPPP annual conference, New York City, January 1990).
2. Adolescent Pregnancy Prevention Clearinghouse, *Opportunities for Prevention: Building After-School and Summer Programs for Young Adolescents* (Washington, DC: Children's Defense Fund, 1987).
3. Joy G. Dryfoos, *Putting the Boys in the Picture: A Review of Programs to Promote Sexual Responsibility Among Males* (Santa Cruz, CA: Network Publications, 1988).

4. Ibid.
5. Ibid.
6. S. K. Tucker, "Adolescent Patterns of Communication About Sexually Related Topics," *Adolescence* (Vol. 24, No. 4, 1989); and Louis Harris and Associates, "American Teens Speak: Sex, Myths, TV and Birth Control," poll conducted for Planned Parent Federation of America, as cited in Center for Population Options, *Adolescents and Abortion: Choice in Crisis* (Washington, DC: Center for Population Options, 1990).
7. Search Institute, "What Influences Teenagers' Decisions About Sex?" *Source* (Vol. 4, No. 3, July 1989).
8. S. N. Davis and M. B. Harris, "Sexual Knowledge, Sexual Interests and Sources of Sexual Information," *Adolescence* (Vol. 17, Summer 1982); and M. Zelnik and Y. J. Kim, "Sex Education and its Association with Teenage Sexual Activity," Family Planning Perspectives (Vol. 14, No. 3, Jul./Aug. 1982), as cited in Dryfoos (see note 3).
9. Affiliate Development of Adolescent Pregnancy/Parent Program, *Those of a Broader Vision: An African American Perspective on Teenage Pregnancy* (New York: National Urban League, 1990).
10. Ibid.
11. Ibid.
12. P. Scales and D. Bechstein, "From Macho to Maturity: Helping Young Men Make Effective Decisions About Sex, Contraception and Pregnancy" in Stuart, I. and Wells, eds., *Pregnancy in Adolescence: Needs, Problems and Management* (New York: Van Nostrand, 1982), as cited in Dryfoos (see note 3).
13. Jacqueline Darroch Forrest and Jane Silverman, "What Public School Teachers Teach About Preventing Pregnancy, AIDS and Sexually Transmitted Diseases," *Family Planning Perspectives* (Vol. 21, No. 2, Mar./Apr. 1989).
14. Anne Thompson Cook, Janet L. Sola and Robin Pfeiffer, *Peer Education in Sexuality and Health* (New York: YWCA of the USA, 1989).
15. Lynne M. Casper, "Does Family Interaction Prevent Adolescent Pregnancy?" *Family Planning Perspectives* (Vol. 22, No. 3, May/June 1990).
16. Analysis of the pretest of the national demonstration project field test of *Human Sexuality: Values and Choices*, as summarized in Search Institute (see note 7).
17. Ibid.
18. Diane Hodson and Karen Wampler, "Social Class and Parental Involvement in the Sex Education of Children," *Journal of Sex Education Therapy* (Vol. 14, No. 2, 1988).
19. "American Teens Speak Out: Sex, Myths, TV and Birth Control," poll conducted by Planned Parenthood Federation of America, 1986, as cited in Claire D. Brindis, *Adolescent Pregnancy Prevention: A Guidebook for Communities* (Palo Alto CA: Health Promotion Resource Center, Stanford Center for Research in Disease Prevention, 1991).
20. Elizabeth Roberts and Steven Holt, "Parent-Child Communication About Sexuality," *SIECUS Report* (Vol. 8, No. 4, 1980).
21. Alan Guttmacher Institute, Teenage Pregnancy: *The Problem That Hasn't Gone Away* (New York: Alan Guttmacher Institute, 1981).
22. M. H. Hamrick, "Parent, Adolescent FLE: An Evaluation of Five Approaches," *Family Life Educator* (Vol. 4, No. 1, 1985).
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24. Steven Schinke, "The Effects of Boys and Girls Clubs on Drug Abuse and Related Problems in Public Housing Projects," a demonstration study sponsored by the Office of Substance Abuse and Conducted under the auspices of the Boys and Girls Clubs of America, 1989.
25. Marilyn Steele, "Good Programs Make a Difference — From a Funder's View", *TEC Networks*: the Newsletter of the Too-Early-Childbearing Networks of Programs Funded by the Charles Stewart Mott Foundation (No. 25, June 1990).

Chapter Five

Collaborations Are The Key

> Middle grade schools cannot meet early adolescents' needs alone. To fulfill their vital functions, they will need to operate at the center of a network of community resources that includes local government, health services, youth-serving organizations, private businesses, and the philanthropic sector.[1]
>
> You can't do it alone. You need the help of other like-minded crazy people who love this age group.[2]

In reality, few urban school systems or youth-serving agencies could offer the range of strategies and services chapters 2 and 4 describe. Consequently, school districts and youth-serving organizations are increasingly looking to collaborative partnerships to provide youth with a full range of activities, resources, and services, offering "multiple sites and multiple methods for fostering the learning and health of adolescents."[3] Such collaborations avoid duplication of services and tap the expertise of many types of organizations that work on pregnancy and risk behavior prevention and positive youth development.

The need for collaborations and the services they provide are proof of great changes that have taken place both in the family and in society at large. The increasing number of single-parent families and of families in poverty, increasing mobility, and high labor force participation by women, combined with the increased years of educational preparation required for economic self-sufficiency, have increased the demand for the formal provision of services that extended families and close-knit communities once provided (health care, child care, and employment training). Many Americans now purchase such services; many others are unable to. Indeed, the gap between the typical services available to middle- and upper-income youth and those available to poor youth is growing even as the need for these services increases. Perhaps the most vital role of collaborations between schools and community-based, youth-serving organizations is to provide low-income youth with the range of activities and supports they need to make a successful transition to adulthood.

Some collaborations, such as the high school academies and Adopt-a-School programs, are primarily school-business partnerships, in which students participate in an integrated academic-technical curriculum, summer or after-school jobs, and a range of support services. In other collaborations, schools and community-based, youth-serving organizations forge partnerships to provide young people with after-school cultural and recreational activ-

ities, counseling, tutoring and career-related activities. UMSAPPP projects forged partnerships in service delivery with a variety of agencies — Girls Clubs, Y's, churches, the Urban League, Planned Parenthood, county and city health departments, neighborhood recreation and cultural organizations, neighborhood clinics, and local colleges.

Services That Collaborating Agencies Can Provide a School or School District

- ***Staff development***: Staff from community-based health organizations can help train teachers in family life/sex education to increase their skill and comfort level in leading discussions on sensitive issues. The Norfolk UMSAPPP project developed relationships with a college and a university to provide staff development on family life education. Staff development can also focus on issues specific to the population served. For example, in the Los Angeles UMSAPPP project, staff from a community-based Hispanic organization led workshops on issues relevant to Hispanic families and culture. Staff development activities can make school staff aware of resources in the community and train them in referral procedures. In Milwaukee, four community agencies joined together to develop a three-day training module for teachers that addressed adolescent development, sexuality, cultural and family issues, and strategies for preventing pregnancy.
- ***Service provision***: Staff from outside agencies can make presentations in schools and provide such services as health screenings, physical exams, emergency care, drug treatment, individual and group counseling, and crisis intervention. In the Kansas City UMSAPPP project, the major collaborating agency, the Adolescent Resources Corporation, undertook extensive health and mental health screenings of students in program schools.
- ***Resources***: Outside agencies can provide materials and financial support for special pregnancy prevention activities, such as health fairs. In Boston, various agencies, including the Alliance for Young Families and Action for Boston Community Development, supported the annual Citywide Teen Forum, sponsored in part by the UMSAPPP project.
- ***Cultural activities***: Community-based organizations can provide cultural activities in schools and in after-school programs. The Detroit and Oakland UMSAPPP projects developed extensive relationships with community-based organizations that gave performances and offered other cultural activities in the schools, often involving students in planning and producing their own cultural programs.
- ***Curriculum development***: Staff from community-based organizations can help schools develop or adapt curricula to the special needs of middle grades students. The Kansas City project developed its own curriculum in collaboration with the Adolescent Resources Corporation and several other community-based agencies.
- ***Mentors***: Outside agencies can provide or help find mentors and can help train and supervise them. In Atlanta, the UMSAPPP project recruited mentors from local

African American organizations, including the Alpha Phi Alpha fraternity at Spellman and Morehouse colleges; in Los Angeles, Hispanic college students from California State University served as mentors for middle grades students whose backgrounds were similar to theirs.

- ***Career activities***: Collaborating businesses and organizations can provide summer or after-school employment opportunities, can be involved in activities designed to increase youth awareness of work options, and can support career-related activities for young people.
- ***Program planning***: Community-based agencies can help schools plan their specific pregnancy prevention activities. In Milwaukee, a consortium of four community-based agencies, including the local Urban League affiliate and the public library, helped teams from individual schools devise school-based building action plans that entailed activities such as parent workshops, health fairs, and presentations for peer education.
- ***Linkages to citywide and statewide efforts***: Community-based organizations can provide linkages to other agencies and to citywide and statewide pregnancy prevention efforts. For example, in Milwaukee, the UMSAPPP project gained access to state funding through its participation in the Wisconsin Life Options Coalition.
- ***Provision of family planning***: Family planning clinics can provide sexuality counseling and contraceptives for students referred by school nurses or counselors.
- ***Access to families***: Collaborations can improve schools' access to families. In Milwaukee, in a school district where middle grades school students were bused from other neighborhoods, the PTA held meetings in a library situated in a community where many students lived.

The Advantages of Collaborations

While school-community collaborations pose certain difficulties, they can, if planned and implemented effectively, strengthen both the school's and the collaborating agency's capacity to work successfully with youth.

Providing Access

First and foremost, school-community collaborations make sense simply in terms of the access to the population they provide for community-based agencies and organizations. Schools are the community institutions with the greatest access to adolescents — those considered at risk and those who are not. Providing services on-site minimizes access problems and makes it possible to design and integrate services as positive support rather than as add-on "treatments." This can help avoid the stigma often attached to use of services. Further, while schools have greatest access to youth at this age, community-based organizations often have much better access to families. Thus, school-community partnerships can allow for greater input from the families of the young people they want to serve.

Providing Resources

Collaborations provide schools with many added resources — of both funds and people — and are an effective way of providing services without straining school budgets and school staff energy. Collaborations broaden the range and variety of services available to schools and enable schools to address complex adolescent needs. Doctors, nurse practitioners, social workers, community workers, and artists not only provide different adult interaction, but also offer specific expertise in addressing the range of adolescent needs.

Providing Flexibility

Collaborative programs offering services in schools can provide greater flexibility than programs offered by schools alone. Community agencies are often smaller and operate with fewer restrictions than schools. They can offer extended hours and provide outreach and additional services to parents, thereby expanding the impact of programs:

> Schools can't provide comprehensive services, and if they try to, they bureaucratize it. They want to do it their way. Collaborations can infuse a "problem-solving" attitude into a cumbersome school bureaucracy. — Community-based agency director

Reducing Fragmentation and Enhancing Coordination of Services

Often, different agencies provide services to youth for different problems. This approach creates a problem-focus that ignores the overlapping nature of many adolescent needs. Collaborations can help reduce this fragmentation and can increase the coordination of services to the families of adolescents:

> Collaborations can provide "one-stop services." Students and families can work with the same service provider, and similarly, a professional can work with a student on school and home problems simultaneously. — Community-based agency staff member

Reducing Duplication of Services

Collaborations can reduce the duplication of services and the resulting confusion about the most effective delivery of services. For example, many community-based organizations may offer homework help, or remedial or tutorial after-school services, but none are held accountable for improving the achievement levels of students in a particular school. Collaborations provide a great opportunity, one community-based agency director attested, "for organizations to complement each other, to bring their particular expertise to bear on the task."

Relieving Teachers

Collaborations take the burden off individual teachers and in general make the provision of services less burdensome to educators:

> Collaborations mean that teachers and schools are not totally responsible for coming up with everything the students get. You can get ideas from people who have already done a lot of work in the field. — UMSAPPP family life education teacher

In particular, collaborations can help individual teachers present sensitive material. Although some UMSAPPP project staff felt that outsiders occasionally experienced difficulty establishing rapport with students on sensitive issues, most felt that these presentations helped teachers more than hindered them:

> It was difficult for me to initiate the sexuality units. I felt better doing the follow-up discussion. — UMSAPPP family life education teacher

> I think students respond better to people they don't see all the time. We teachers are similar to parents when it comes to discussing sex. — UMSAPPP family life education teacher

Many UMSAPPP staff members spoke of the collegiality that collaborations provided:

> The greatest advantage of collaboration was having people both school-based and in the community to share ideas with, to get feedback and support from. Having this kind of support makes you more willing to take risks. — Community-based agency director

Underscoring Legitimacy

Equally important, collaborations support the legitimacy of pregnancy prevention activities, especially in communities where these activities engender controversy:

> Collaborations take the heat off individual school administrators. They give you a firmer and a broader base in the community. The more respected the agencies you work with, the firmer this base will be. — District administrator

Closely related to the above, collaborations lend a greater objectivity to evaluation:

> Having people who are not school-based to help plan and evaluate program activities gives you a more objective view of what's going on and its impact on student behavior. — UMSAPPP project director

Communicating Important Messages

School-community collaborations are based on a recognition of both the communitywide aspects of the problems facing youth and the shared responsibility that finding solutions to these problems must entail. Such collaborations reflect a commitment on the part of schools and youth-serving agencies to bring together resources and expertise to meet the needs of youth:

> Collaborations send out an important message to schools in an age when educators are overburdened by the number of problems they are expected to address. Collaborations show schools that they don't have to do it alone. — Middle grades school principal

Just as important:

> Collaborations send out a clear message to youth-serving organizations that schools are open to input from the community in addressing the needs of youth. — Community-based agency director

Perhaps most important of all, collaborations can give young people an important message about the relevance of what they are learning to the world of work:

> To introduce young people to the world of work, to convince them of the importance of staying in school, what better way than to bring talented and concerned individuals from the community to be positive role models and to convince young people of the importance of education and making healthy choices? — Community-based agency director

The major disadvantage to working collaboratively is that it is time-consuming:

> I see nothing but advantages to collaborations. They are a rich source of expertise. They provide more resources, more ideas, and more people. But they take time, time, and more time — especially at first, as school and agencies learn to work together. — Middle grades school principal

(Chapter 16 addresses the problems of collaborations and strategies for promoting effective collaborations.)

Resources

The following books are extremely useful resources for community-based agencies and schools seeking to work collaboratively. They describe numerous successful coalitions and provide suggestions for implementation.

Brindis, Claire D. *Adolescent Prevention Pregnancy: A Guidebook for Communities.* Palo Alto, CA: Stanford University, Health Promotion Resource Center, Stanford Center for Research in Disease Prevention, 1991.

Lindsay, Jeanne and Sharon Rodine. *Teen Pregnancy Challenge. Book 1. Strategies for Change: Developing Adolescent Pregnancy Prevention Programs,* and *Book 2. Programs for Kids: From Primary Prevention to Parenting Support.* Buena Park, CA: Morning Glory Press, 1989.

Notes

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2. Lorraine Monroe, Special Consultant, Center on Minority Achievement, Bank Street College of Education (Presentation at an annual UMSAPPP conference, New York City, January 1990).
3. Carnegie Council (see note 1).

PART TWO

PREGNANCY PREVENTION STRATEGIES

Chapter Six

Family Life/Sexuality Education

> I found out things my parents would never tell me. I never thought about the consequences of what I do before but now I do. — UMSAPPP student
>
> Students start to realize how their futures can be affected adversely by a wrong choice in the present. — Family life education teacher

Family life/sexuality education must be a vital part of any middle grades pregnancy prevention program. A range of curricula is currently in use in sexuality education, family life, and human growth and development. These curricula nearly always cover human reproduction and conception, adolescent development and sexuality, pregnancy and parenthood, and sexually transmitted diseases. They offer units on peer pressure, setting educational goals, relationships, family values, and activities enhancing communication and decision-making skills and assertiveness. Some curricula cover gender and racial stereotypes and contraception; a few cover homosexuality and sexual variation. Most emphasize abstinence as the wise choice for middle grades students.

The major goals of such curricula are to

- Increase student knowledge of physical and sexual development
- Help students be sexually responsible
- Enhance students' sense of competence
- Improve students' communication and decision-making skills and their ability to resist peer pressure

Helping Students Make Informed Choices

> We want to help students realize that they don't live in a choiceless world. — Middle school principal

Many practitioners want to help students make informed choices — choices informed both by a knowledge of contraception and, much more important, by a sense of the employment and education options that too-early parenthood could curtail. Even more fundamentally, some practitioners want to help young people — especially girls who come from com-

munities where women have not traditionally had choices regarding work and education — realize that they have choices:

> Our major purpose in our family life curriculum was to help students understand who they are, where they're going, and how they're going to get there. We placed a great deal of importance on self-awareness, cultural awareness, goal setting, and personal achievement against all odds. As students begin to plan their lives, it becomes more and more apparent to them that they have to concentrate on the good and bad choices people make and how those choices will affect the goals they have set for themselves. — UMSAPPP project director

A major component of helping young people realize that they have choices is to increase their sense of future educational and employment options and equally important, to help students understand the connection between choices regarding pregnancy and parenthood and future education and work. Increasingly, practitioners speak of the need to include career awareness education and goal-setting activities in traditional family life education courses in order to motivate young people to avoid too-early pregnancy and parenting.

The Center for Populations Options' curriculum, Life Planning Education: A Youth Development Program (LPE), does just this, by infusing traditional sex education with career awareness and decision-making education. Its major goal is to provide teens with the information and skills they need to approach two of the most important tasks they face: dealing with their sexual and reproductive development, feelings and behavior, and preparing for the world of work. A major emphasis is on helping teens set educational and vocational goals and understand the connection between achieving these and delaying parenthood: "Teens who participate in Life Planning Education can learn that their educational and vocational goals will affect plans for a family and that their sexual decisions will affect their vocational choices."[1]

LPE has three major units:

- "Who Am I?" helps teens explore their feelings, values, interests and strengths
- "Where Am I Going?" helps set education and vocational goals
- "How Do I Get There?" increases teen knowledge about sexuality, family planning, job-seeking and communicating effectively

LPE covers self-identity, personal and family values, sex roles and stereotypes, goal setting and decision-making, parenthood, sexuality and contraception, and communication and employment skills. The curriculum also has a unit on AIDS/HIV.

Making Family Life Education Engaging

> What made the family life sessions effective was the way in which information was delivered. Lectures usually resulted in students turning a deaf ear or becoming bored quickly. You just can't have dry presentations of biology and anatomy. — Family life education teacher

> You have to develop strategies that appeal to concrete thinkers and help them under-

> stand abstract concepts. You have to create structured situations and activities that allow them to gain information, express themselves, . . . ask questions, and . . . learn how to behave responsibly. These students have a thirst for knowledge related to teen sexuality, but you have to present it in a way that grabs them. — Family life education teacher

How a teacher presents material in a family life education course is as important as the material itself. Over and over, educators stress that students at this age cannot sit still for dry, large group presentations. One UMSAPPP teacher advised: "You have to make classes as active as possible to involve students. Students get bored very quickly, especially if they feel they've heard it all before." In fact, students may have heard it before. One eighth-grade youngster declared: "It was nice, but it seemed everybody had heard it all before. We've had this all so many times since grade six!"

Most programs try a variety of approaches to convey the information to students as actively as possible, including bringing in consultants and speakers to make presentations and lead discussions; using videos, music, role-playing and games; conducting small group discussions; and using drama and skits. Role-playing seems particularly suited to this age group. One UMSAPPP teacher recalled: "Students created plays of real-life situations and acted them out; a group discussion of possible solutions followed. These kids have a lot of creativity, and these kinds of plays really brought it out." Teachers and students alike reported that some of the best activities were those that helped teens understand the responsibilities of early parenthood — skits, role playing, small group discussions, videos, activities like the "egg baby" (described in the Life Planning Education curriculum) or the "flour sack baby," and presentations by teen parents.

> These activities help teens realize that they are not invulnerable — that it could happen to them. — Family life education teacher

> Listening to teen mothers talk about what their lives were like was an eye-opener to me. I realized that once you have a kid, there's no more hanging out. It made me realize that it's more responsibility that I can handle at this point in my life. — UMSAPPP student

As discussed in chapter 5, staff from collaborating agencies can provide many of the specific activities in a school-based family life education course. In such cases, it is vital to verify that the person making the presentation has a good sense of what is age-appropriate:

> No matter how well planned we thought our life planning course was, it only took one guest speaker to cause local and regionwide concern. That incident taught us to screen potential speakers and any materials they wanted to distribute very carefully to make certain they were age-appropriate. — UMSAPPP project director

Family Life/Sex Education Evaluated

Various studies have shown that family life/sex education is necessary but not sufficient to have an impact on teen behavior. Specifically, family life education does not lead to earlier

(or later) initiation of sexual activity, increased frequency of coitus or to a reduction in pregnancy rates, although it may lead to improved use of contraception.[2] However, a four-year study of eight community- and school-based sex education programs provides evidence that sex education can have an impact both on choosing abstinence and on using contraception. In the study, 1,400 teens aged 13–19 were randomly assigned to experimental or standard sex education classes. The standard classes relied on handouts, lectures, and films, while the experimental classes relied more on role-playing, lengthy discussions of birth control, and activities that focused student attention on the likelihood of pregnancy.

After one year, males in the experimental program were more likely than males in the standard class to abstain or to use contraception effectively. One reason for this could be that the personal interactions and role-playing activities — specifically, those in which young men played the roles of young women being pressured to have sex — and other personal interactions may have forced teenage boys "to examine and think about their dating and sexual interactions in new and unsettling ways. This experience may have given them a new awareness of the risks their sexual partners face."[3] Changes in behavior were less dramatic for females. The fact that the program worked best for males — and for males who were sexually active at the beginning of the study — also led to the conclusion that "programs must be client-specific: one program model does not work equally well for everyone."[4]

Specific Curricula

When initiating pregnancy prevention programming, it is tempting to start from scratch by developing a new curriculum especially responsive to the needs of a particular group of students. However appealing this may be, it is probably advisable to resist this temptation. Developing a curriculum is an expensive, time-consuming endeavor, especially when other activities are also being initiated. A number of good curricula are available; seven of these are listed in the resources at the end of this chapter. Programs can adapt units or develop new ones where existing curricula do not respond adequately to the needs of particular groups of students. Similarly, practitioners already using one curriculum can adapt units from others to address a topic not covered or inadequately covered in their curriculum. Most practitioners agree that no matter how good a curriculum is, frequent adaptation and revisions are usually necessary.

Important Issues in Family Life/Pregnancy Prevention Education

Pregnancy prevention programming must be broad enough to engage teens and to motivate them to avoid too-early pregnancy and parenting. At the same time, it must maintain the prevention focus. Three issues are particularly important in this regard.

Mixed Messages

Young people in our society receive very mixed messages about sex, pregnancy, birth control and motherhood. As noted in chapter 1, these mixed messages may be one of the

primary causes of our high teen pregnancy rates. On the one hand, sex is omnipresent in our culture, and young people get many messages, direct and indirect, to "just do it." On the other hand, there remains a sense that "good girls should say no."

Our society glorifies pregnancy and motherhood, portraying pregnant women as quintessentially feminine, and motherhood as the acme of a woman's life. Our culture has become more and more centered on the child as consumer, and products geared to infancy and early childhood are burgeoning. Rarely on television do we see images of women struggling with motherhood or any realistic depiction of the conflicts of careers and parenthood.

Yet, our society often treats a teen's pregnancy as a big problem, and a pregnant girl as a failure. Or, equally confusing, the pregnant young woman, having had teachers and family tell her not to get pregnant, gets positive feedback from peers and then enters a program where she receives individual attention and has the best educational experience of her life. In cases where mothers reject young women who become pregnant and forgive them when the baby is born, the confusion is compounded. These mixed messages about sex and motherhood have the greatest impact on young women from communities and cultural groups where few alternative role models to motherhood are present.

The Problem is Timing

Teenagers can get mixed messages about pregnancy, particularly in a program where sexual activity is lumped together with behaviors that young people should avoid totally. It is important to remember that the problem is *too-early* sexual activity, pregnancy, and parenthood:

> Pregnancy is not like other risk behaviors. We don't want the girls to reject motherhood. We don't want students to think that sex and pregnancy are bad. They aren't something that we don't want them ever to do, like drugs. We just want them to wait until they can handle them and protect themselves from the negative consequences. — UMSAPPP project director

Keeping the Focus

It is important not to lose the pregnancy prevention focus in family life education activities. This sometimes may happen because the focus of family life education courses expands to include career education or activities to enhance decision-making skills, or because teachers are reluctant to provide information about contraception and access to it:

> You find people doing pregnancy prevention, and they're doing everything else but. It's a great program, but it's not about pregnancy prevention. — Middle school counselor

Resources

Fay, Joseph and Mary Grace Umbel. *Human Development Series: A Sexuality Education Program for Adolescents.* York, PA: Planned Parenthood of Central Pennsylvania, Inc., 1981.

Includes units on sex roles, emotional growth and physical changes of puberty, homosexuality, sexual variation, peer pressure, sexual exploitation, love, family values. Contains values clarification and decision-making activities with each topic. Stresses the development and importance of values as they affect decision making.

Forliti, John, Lucy Kapp, Sandy Naughton, and Lynn Young. Human Sexuality: Values and Choices. Minneapolis: Search Institute, 1986.

A 15-unit curriculum geared to seventh and eighth graders. Contains units on self-esteem, physical and emotional changes during early adolescence, making choices, pregnancy and childbirth, dating, sexually transmitted diseases, sexual abuse, sexism, and planning for the future. "Booster" curriculum available. Teachers' guide contains three sessions for parents; parents' guide available in both Spanish and English.

Girls Clubs of America, Inc. Preventing Adolescent Pregnancy. Indianapolis: Girls Incorporated National Resource Center, 1985.

A four-part curriculum developed by Girls Clubs of America (now Girls Incorporated). The first part, geared to girls aged 9–11, is Growing Together, a curriculum designed to encourage communication within families about physical development, sexuality, and values. Will Power/Won't Power, an assertiveness training program encourages girls, aged 12–14 to postpone sexual involvement. Health Bridge provides a link with health services available in the community and encourages girls to view reproductive health and contraception in the context of general health and wellness. Taking Care of Business helps girls 15–18 set educational and career goals and understand the relationship between choices regarding parenting, education and employment. This curriculum was field-tested for three years in eight cities and is now being replicated in Girls Incorporated centers across the country. It may be available in the future to nonaffiliated groups.

Gray, Mattie Evans. *Images: A Workbook for Enhancing Self-Esteem and Promoting Career Preparation (Increasing Minority Aspirations Through Gender Equity for Students)*. 1988.

A self-esteem enhancement and career awareness program, described in chapter 4.

Hunter-Geboy, Carol et al. *Life Planning Education: A Youth Development Program*. Washington, D.C.: Center for Population Options, 1988.

Helps teens deal with the major developmental tasks of adolescence. Emphasizes the importance of setting goals and the connection between delaying parenthood and achieving educational and employment goals.

Matiella, Ana Consuelo, ed. *The Latino Family Life Education Series*. Santa Cruz, CA. Network Publications 198890.

Family life education curriculum geared to Latino middle grades youth, described in chapter 4.

Public/Private Ventures. *Life Skills and Opportunities*. Philadelphia: Public/Private Ventures, 1984.

Curriculum used in the Public/Private Ventures Summer Training and Education

Program (STEP); major goal is to help young men and women assume responsibility for their futures "by learning to make informed choices about their own social and sexual behavior." Has units focusing on preparing young people for employment and helping them avoid unintended pregnancy; covers goal setting, assertiveness, stereotypes, relationships, making decisions about sex, contraception, and preparing for the world of work. Available to organizations for integration in their youth programming, in conjunction with P/PV training, on a competitive basis.

Notes

1. Center for Population Options, *Life Planning Education: A Youth Development Program* (Washington, DC: Center for Population Options, 1988).

2. Douglas Kirby, *Sexuality Education: An Evaluation of Programs and Their Effects*, Vol. 1 (Atlanta, GA Bureau of Health Education, Centers for Disease Control, 1984) William Marsiglio and Frank L. Mott, "The Impact of Sex Education on Sexual Activity, Contraceptive Use and Premarital Pregnancy Among American Teenagers," *Family Planning Perspectives* (Vol. 18, No. 4, July/Aug. 1986); and Deborah Anne Dawson, "The Effects of Sex Education on Adol· scent Behavior," *Family Planning Perspectives* (Vol. 18, No. 4, July/Aug. 1986).

3. Marvin Eisen, Gail L. Zellman and Alfred McAlister, "Evaluating the Impact of a Theory-Based Sexuality and Contraceptive Education Program," *Family Planning Perspectives* (Vol. 22, No.6, Nov./Dec. 1990).

4. Ibid.

Chapter Seven

Postponing Sexual Involvement

> One of the biggest myths we have to deal with is the myth that everybody's doing it. — Sex education teacher

> One of the common reasons given by pregnant and parenting teens for early sexual involvement is not knowing how to say no without hurting the other's feelings, without losing one's partner altogether, without looking prudish or out-of-date in the eyes of one's crowd.[1]

Encouraging young teens to postpone sexual involvement is part of most pregnancy prevention programs in the middle grades. Most practitioners see this as a necessary, if partial, response to the problem — to minimize sexual activity and thereby minimize its negative consequences. Programs encouraging abstinence as the best choice for young teens are based on research showing these findings:

- Sexual activity is not the norm for young teens: "While sexual expression is a positive, healthy part of being human, engaging in sexual intercourse is not at all the norm for early adolescents; that, in fact, by the time they reach 15, four out of five girls have never had intercourse."[2]
- Most early adolescents have not yet developed the cognitive, behavioral, and communication skills required of serious decision making and are therefore unable to use contraception effectively.[3]
- Teens want to say no. In one random sampling of sexually active girls 16 and younger conducted by the Emory/Grady Teen Services Program, 84 percent said that they wanted "to learn how to say no without hurting the other person's feelings."[4]
- Traditional sex education has had virtually no impact on rates of teen sexual activity.[5] In the mid-seventies, an evaluation of a program involving over 30,000 eighth graders found that by the 10th grade, most of the students sampled for the study "had learned a lot but not changed their behavior." The conclusion of the Emory/Grady Teen Services Program in Atlanta, which administered the program, was that the students were not unaware of the possible negative consequences of risk-taking behavior; they simply had not been able to adjust their behavior. The investigators concluded that young people of this age begin having sexual intercourse more because of social and peer pressures than because they lack knowledge.[6]

Programs encouraging postponement of sexual involvement, as well as those hoping to reduce negative behaviors like smoking, are based on the "social influence" or "social inoculation" model:

> This model uses the public health concept of immunization as a strategy for combating social and peer pressures that encourage negative health behaviors. By exposing teens to these "noxious" social influences in small doses, while at the same time enabling them to examine such influences and develop skills to deal with them, this strategy helps teens eventually build up an "immunity" to them.[7]

Programs based on the social influence model employ specific activities and strategies to recognize, understand, and resist the many pressures the media and their peers exert on teens to engage in risk behaviors. Such programs also employ older teens to present material, role-play responses, and lead discussions:

> Besides imparting attitudes and skills, slightly older teenagers illustrate that those who "say no" to the pressured behavior can be admired and liked by others. They also clearly demonstrate to the younger teenagers that the behavior — for example, having sex — is not the way to attain such status.[8]

Abstinence education allows young people to share their values publicly. Announcing their decision to wait can help reinforce this decision and give young people encouragement in the face of social and media pressures; it can also help destroy the misconception that all young people are sexually active.

Postponing Sexual Involvement: An Educational Series for Young Teens (PSI) is a five-session abstinence curriculum modeled on programs developed to discourage students from smoking and drinking. The Emory/Grady Teen Services Program in Atlanta designed PSI to be integrated into the eighth grade human sexuality curriculum, after the survey described above illustrated that the existing curriculum — focusing on sexuality, contraception and decision making — was not enough. The complete 10-period curriculum is presented to all eighth grade students in 19 schools (including several schools in which the Atlanta UMSAPPP project was located). Older teens present the PSI curriculum: typically one male and female student from grade 11 or 12 lead each session. In this way, PSI seeks to reverse negative peer pressure by giving teens positive models of older teens. Emory/Grady Teen Services Program staff recruit, train and supervise teen leaders on-site. These teens receive payment for the classes they give and in some cases earn high school credit for their participation.

PSI specifically helps students understand the media, social and peer pressures that lead them into early sexual activity. Through group discussions and practice in applying skills to problem situations, it also helps teens develop the ability to resist these pressures. Specifically, PSI teaches teens three techniques: Keep repeating no without making excuses; tell the other person how his or her pressure makes you feel, or ask why he or she is continuing to pressure you after you have said no; refuse to discuss the matter any further, even walk away. As one teen who took PSI said: "I learned that I can say no and not have to explain why."

An evaluation of PSI focusing on students at highest risk for early sexual involvement and premature pregnancy showed positive results. A comparison group of students who had not yet had sex and who had not taken PSI were five times more likely to become sexually involved in the eighth grade than were similar students who had taken the program.[9] By

the end of the ninth grade those given the PSI program were still significantly less likely than the comparison group to be sexually active: 24 percent of students who had participated in the program had initiated sex, compared with 39 percent of students who had not.[10] Although the program had no effect on those who had had sex before its implementation, students who began having sexual intercourse after the PSI program reported less sexual involvement than students in the comparison group. The director of the program concluded that "PSI is a tool that gives both boys and girls some control over their behavior."[11]

Promoting Abstinence Is Not Enough

Most practitioners agree that encouraging teens to remain abstinent is a necessary but partial response to preventing teen pregnancy in the middle grades. It must be combined with other programming and supports to help young people stay in school and avoid risk behaviors. As one middle school counselor put it: "It isn't either-or anymore. We have to push for abstinence. But in the meantime, we have to help kids do better in school; we need teen centers and after-school programs; we need to give young people alternative recreational activities."

Practitioners also stress that programs should not focus on abstinence to avoid the issue of birth control. Nor do they recommend abstinence curricula like Teen Aid and Sex Respect, which focus solely on teaching abstinence from sexual intercourse until marriage. Sex Respect, in particular, includes few references to other methods of protection from pregnancy and sexually transmitted diseases (and those few are usually negative) and does not seek to empower students to make healthy choices.

Resources/Curricula

American Home Economics Association, *Project Taking Charge*. Arlington, VA: The American Home Economics Association, 1990.

> Six-week abstinence curriculum targeted specifically to seventh and eighth graders. Designed to help teens understand the relationships among and consequences of too-early sexual activity, pregnancy and childbearing and the attainment of educational and vocational goals. Covers goals and values, self-esteem, decision making, psychosexual development, vocational planning and parent-child communication. Contains a "job shadowing" component in which students observe and interview community members in various job settings.

Girls and Boys Clubs of America. *Smart Moves*. New York: Girls and Boys Clubs of America, 1990.

> A four-part abstinence curriculum designed specifically to help boys say no to alcohol, drugs and early sexual activity. One unit, "Start Smart," is geared to 10–12-year-old boys; "Stay Smart" is geared to 13–15-year-olds. Also has a component for parents. Currently in use in 200 Boys Clubs across the country.

Howard, M. M. Mitchell and B. Pollard. *Postponing Sexual Involvement: An Educational Series for Young Teens*. Atlanta: Grady Memorial Hospital, rev. 1990.

A video version of this curriculum is available for use by adults who do not choose to use teen leaders. A parent version and age-appropriate adaptation for fifth and sixth graders is also available. (Available from Emory/Grady Teen Services Program, P.O. Box 26158, 80 Butler Street, SE, Atlanta, GA 30335-3801.)

Notes

1. Girls Incorporated, *Preventing Adolescent Pregnancy* (New York: Girls Incorporated, 1990).
2. Ibid.
3. Steven Paul Schinke, "Preventing Teenage Pregnancy," *Progress in Behavior Modification* (Vol. 16, 1984).
4. Marion Howard, Director, Emory/Grady Teen Services Program (Presentation at UMSAPPP annual conference, New York City, January 1990).
5. Douglas Kirby, *Sexuality Education: An Evaluation of Programs and Their Effects*, Vol. 1 (Atlanta: Bureau of Health Education, Centers for Disease Control, 1984; William Marsiglio and Frank L. Mott, "The Impact of Sex Education on Sexual Activity, Contraceptive Use and Premarital Pregnancy Among American Teenagers," *Family Planning Perspectives* (Vol. 18, No. 4, July/Aug. 1986); and Deborah Anne Dawson, "The Effects of Sex Education on Adolescent Behavior," *Family Planning Perspectives* (Vol. 18, No. 4, July/Aug. 1986).
6. Marion Howard, "Helping Youth Postpone Sexual Involvement," In D. Bennett and M. Williams, eds., *New Universals: Adolescent Health in a Time of Change* (Curtin, Australia: Brolga Press, 1988).
7. Marion Howard and Judith Blamey McCabe, "Helping Teens Postpone Sexual Involvement," *Family Planning Perspectives* (Vol. 22, No. 1, Jan./Feb. 1990).
8. Ibid.
9. Marion Howard, director, Emory/Grady Teen Services Program (Presentation at UMSAPPP annual conference, New York City, January 1990).
10. Howard and McCabe (see note 7).
11. Marion Howard, Director, Emory/Grady Teen Services Program (Presentation at UMSAPPP annual conference, New York City, January 1990).

Chapter Eight

Counseling

> Small groups provide a unique opportunity for adolescents to process information. They allow teens to hear each other and to be heard in a way that encourages attainment of program goals and objectives more readily than in a traditional classroom format.[1]

Counseling — both group and individual — is an important component of many programs dealing with early adolescents. The Teen Outreach program, the Early Adolescent Helper program, and Each One/Reach One (described later in this handbook) are among the programs that include small group discussions and counseling in their strategies for helping at-risk youth. In addition, many family life/sex education courses use small groups to reinforce certain aspects of the curricula, especially information presented in a large group or assembly. For example, the Atlanta UMSAPPP project formed school support teams, consisting of teachers, school nurses, and counselors, which held weekly small group sessions to provide in-depth discussion of issues that arose in family life education classes.

Small groups offer teens peer supports they especially need at this age. They provide teens a safe environment in which to express and assess their own values and learn from the values of their peers. Small groups can be ideal for dispelling myths about sexuality, since group members often do not share the same misconceptions: "There is always at least one peer who can reality test for another, and the fact that it is a peer who provides the evidence gives greater meaning to the information."[2]

Small group counseling is based on the belief, central to much prevention work, that teens need more than information to avoid too-early intercourse and pregnancy. They need the cognitive skills to make decisions regarding sexual activity and contraceptive use; they need the communication skills to convey these decisions; and they need the behavioral skills to carry them out.[3] Small group counseling is also based on the social work small group model. This model uses concepts such as "empowerment, the relationship as a basis for helping, and the power of mutual aid."[4] Two major assumptions underlie the model: that individuals retain and use information only if they can integrate it into what they already know in a way that makes sense; and that decisions to adopt or reject new ways of thinking are usually the "result of a process that is best done through interaction with significant others, i.e., people whose opinions matter."[5]

Both of these assumptions imply that the way in which information is imparted is as important as the information itself: "Given the enormous influence the peer group has on adolescents, it seems logical, then, to use the small group to help teenagers carry out those tasks which are requisite to making thoughtful decisions about their sexuality and sexual behavior."[6]

Teen Choice

Counseling, both small group and individual, is the core of Teen Choice, a pregnancy prevention program run by Inwood House, a New York City community-based agency serving young women and their children. Inwood House initiated the program in 1978 when the New York City Board of Education asked it to provide school-based services to reduce the incidence of teen pregnancy. Teen Choice offers students in grades 7-12 information, counseling, and referrals regarding human sexuality, family planning, pregnancy, parenting, and sexually transmitted diseases. The program has three major components: classroom presentations, small group counseling, and individual counseling. It operates in two junior and six senior high schools. Teen Choice's six major goals are to:

- Reduce teen pregnancy
- Provide information about all aspects of human sexuality
- Provide information about sexually transmitted diseases, including AIDS
- Help young people make responsible choices about sexual activity
- Help young women and men communicate more openly about sex and relationships
- Encourage young women to assume more active and empowering roles in relationships

The small group process is the "heart and soul of the Teen Choice program."[7] Small discussion groups on a range of topics — sexuality, peer pressure, contraception, relationships — take place weekly at participating schools. A social worker trained in adolescent development and human sexuality leads each discussion. He or she recruits group participants and maintains contact with school staff. Groups typically have 12 members. In high schools, they meet for 12–14 sessions during the semester. In junior highs, they sometimes meet for the entire year. High school groups are coed, but junior high groups are often single sex because young people of this age do better with members of their own sex. Participation in the program is voluntary.

Guided by the leader, group members establish rules of communication and group behavior that encourage a respectful exchange of views and questions. The group leader is a role model, demonstrating acceptance and respect. The group deals with questions of a personal nature in ways that elicit the underlying values. For example, "When did you start having sex?" becomes "When is a good time to start having sex?" Group rules exempt individuals from having to talk about their experiences. The group leader answers sensitive questions objectively and tries to elicit group members' opinions and values.

Teen Choice social workers convey the message that sexuality is a normal aspect of adolescent development. However, leaders encourage students to postpone intercourse and parenthood until they are emotionally, physically, and financially capable of handling the consequences. They also encourage students who choose to be sexually active to use contraceptives consistently.

Results of a three-year evaluation of Teen Choice were encouraging: participants' knowledge had increased and those who were sexually active had improved their contraceptive use and had continued this improved use over time.[8]

Life Skills Counseling

Life Skills Counseling is a cognitive-behavioral approach to pregnancy prevention based on the premise that rather than lacking the information necessary for responsible sexual behavior, adolescents lack the cognitive and behavioral skills necessary to use that information. This model, which has been used in programs serving a variety of populations — Native Americans, teen mothers, Hispanics, and middle grades students — is aimed at developing and enhancing young people's communication skills and assertiveness regarding sexual behavior and substance abuse.

Trained graduate students present the 10-hour intervention to fifth and sixth graders. The curriculum consists of providing information, teaching problem-solving skills, practicing refusal skills, discussing interpersonal communication, and training teens to understand media pressures. It teaches about responsible sexual behavior in four steps:

1. *Providing young people ongoing access to information*: Young people need information on human sexuality, pregnancy, abortion, and contraception; they will base their decisions and behavior on what they learn. Information must be relevant — unasked questions should not be answered — and not overly technical.
2. *Ensuring that young people comprehend, store and retain this information accurately.* This is essential, since what is presented often differs greatly from what is received about sex, and since adolescents often have much misinformation about sex even when they have been exposed to sex education. Methods of ensuring accurate storage of information include rehearsal, frequent monitoring, periodic quizzes, social reinforcement, and tangible rewards. The small group is ideal for these activities, allowing group leaders to correct and reinforce participants' responses.
3. *Helping young people personalize and use this information in making effective decisions.* "Adolescents must make the transition from passively being aware of sexual facts to actively using these facts in planning and decision making."[9] This means that adolescents must integrate specific abstract facts about sexuality into their system of beliefs and values. For example, the fact "Unprotected intercourse risks pregnancy" becomes the self-referential statement "Every time I have intercourse with my girl friend without using contraceptives, we risk pregnancy."[10]

The group process is ideal for this kind of personalizing of abstract information since it allows for sharing and reinforcement. Listening to group experiences can help members envision using this personalized knowledge in future decision making. The group is also ideal for helping members visualize consequences of specific decisions and for generating alternative decisions.

4. *Helping young people develop behavioral skills to use these decisions in social situations.* This stage involves training young people to implement their decisions through modeling, role-play, reinforcement, practicing verbal and gestural responses, and coaching. Students practice refusing in four steps: stopping, thinking, deciding, and acting. This stage of the process involves young people's reporting on actual experiences they have had and how those experiences reflect the skills they have learned in the group.

In one evaluation of the life skills counseling approach, researchers randomly selected

two classes in each of 24 schools to receive the 12-session life skills treatment or the regular curriculum. They took measurements before, just after, and six months after the program. The group that received the life skills counseling displayed greater knowledge about birth control, communication with parents about pregnancy prevention, intentions to use, and actual use, than the control group; the differences were especially marked for students who initiated sex after the course. No differences in rates of sexual activity were evident.[11]

Resources

Life Skills Counseling

For information about the Life Skills Counseling model, contact Professor Steven Schinke, Columbia University School of Social Work, 622 West 120 Street, New York, NY 10025.

Inwood House Community Outreach Program (Teen Choice), 320 East 82 Street, New York, NY 10028.

Has a training and consultation component to assist agencies, schools, and communities that seek to replicate in some fashion the Teen Choice model of sexuality education/pregnancy prevention counseling; is preparing curriculum for publication.

Notes

1. Inwood House Community Outreach Program (Teen Choice), *Summary Report for the 1988-89 School Year*, August, 1989.
2. Dominique Moyse-Steinberg, "A Model for Adolescent Pregnancy Prevention Through the Use of Small Groups," *Social Work with Groups* (Vol. 13, No. 2 1990).
3. Steven Schinke et al. "Preventing Unwanted Pregnancy: A Cognitive Behavior Approach," *American Journal of Orthopsychiatry* (Vol. 49, No. 1, January 1979).
4. Moyse-Steinberg (see note 2).
5. Schinke et al. (see note 3).
6. Ibid.
7. Inwood House (see note 1).
8. Ibid.
9. Schinke et al.(see note 3).
10. Ibid.
11. R. Barth et al. "Preventing Teenage Pregnancy with Social and Cognitive Skills," Unpublished paper, 1990, as cited in Claire Brindis, "Reducing Adolescent Pregnancy: The Next Steps for Program Research and Policy," *Family Life Educator* (Vol. 9, No. 1, Fall 1990).

Chapter Nine

Peer Education

> If someone like me had come to my class to speak when I was coming up, I think that would have made me think twice. So when I go into a classroom, I think about reaching that one kid who needs to hear a message from me to think twice, not just to do something because everyone else is doing it. — Peer educator
>
> I've talked to conferences, parents groups, and high school students, but the groups I like talking to best are the kids in middle schools because they're just coming up. — Peer educator

Increasingly, pregnancy prevention and risk prevention programs are training teens as peer counselors, educators, or facilitators. This approach is grounded in a teen empowerment perspective and is also imminently practical, since all too often, a young person's major source of information about sexuality is a peer who is equally misinformed.[1] As one UMSAPPP teen expressed it: "I used to have a lot of misinformation. I thought that because I'd been sexually active since I was 15 and never gotten pregnant, I couldn't get pregnant." One study of adolescent sources of information about sexuality found that mothers were a main source for information about menstruation and conception, and schools were a primary source of information about sexually transmitted disease. Peers accounted for the information that young people received about most other sexuality issues, specifically contraception, but only one teenager in five was knowledgeable in this area.[2]

Training a network of peers armed with accurate information about sexuality, birth control and related issues can provide teens with reliable sources of information and counter the half truths and myths that are so common among adolescents. In terms of prevention efforts, training teens as educators is developmentally sound, given the needs of early adolescence:

- Young teens have strong needs to take control of their own lives, to be independent, and to rely on each other, as much as on parents and other adults, for support.
- Teens are very influenced by the example of other teens in making decisions about sexuality, school, and work.
- Teens need opportunities to explore their feelings openly among peers who are going through similar experiences.

The major goal of most peer education programs is to empower teens "to make important decisions about important areas of their own lives — sexuality, reproduction, drug

and alcohol use . . . relationships, and other sensitive issues affecting personal health."[3] One of the major methods of achieving this goal is to "infuse accurate information and resources into the peer network by training teens in sexuality and health information, communication and facilitation skills and by providing structured opportunities for teens to share information with their peers, their parents and other adults."[4]

Involving teens in education efforts has several advantages. First and foremost, teens speak the language of teens. As an UMSAPPP staff member put it: "Kids use the right words with kids." Teens will often ask their peers questions that they would be too embarrassed to ask an adult. Conversely, peer educators can ask difficult questions that adults could not easily ask:

> Once a girl with two kids told me that she hadn't used birth control because her boyfriend made all the decisions in the relationship. I asked her why she let that happen. And then I asked her why she let that happen twice! — Peer educator

Another advantage of a trained cadre of peer educators in a school or community is that it allows for flexibility in terms of timing. Whereas classes are available only at scheduled times, peer counselors or educators can be available throughout the day to answer questions or discuss problems — either in person or on a teen hot line:

> With teenagers timing is everything. Teens, like other people, are often most receptive when they have personal questions or concerns — which may or may not coincide with a scheduled program or curriculum.[5]

> Peer educators can sometimes grab that "teachable moment" when teens need help and parents or teachers just aren't available. — Peer educator trainer

Lastly, while evaluation is scanty, at least one study has indicated that peer educators may be more effective than adults in presenting a prevention curriculum. In a follow-up study of a smoking prevention program, investigators compared the smoking habits of students who received a peer-taught curriculum with those of students in a control school who received the same curriculum taught by adults. Three years after the intervention, the incidence of smoking was lower for the former group, and smokers in this school smoked fewer cigarettes.[6]

PACT: Peer Education in Sexuality and Health Program

PACT is a peer education and training program developed by the Cleveland YWCA in response to growing concern about teen pregnancy. PACT teens are trained not as counselors, but as facilitators serving primarily as a "non-threatening source of information and dialogue about sensitive topics."[7] Typically PACT teens work in pairs or small groups and are supervised by an adult when they make presentations. Young people trained in PACT provide numerous services in the community:

- They make presentations on various topics: saying no, sexual decision making, relationships, dating, intimacy and love, date rape, gay and lesbian relationships, gender stereotypes, AIDS, HIV, facts and myths about sexuality and teen pregnancy.

- They run workshops on parent-teen communication.
- They staff information rooms or libraries in local Y's, community centers, or schools.
- They appear as guests on local radio and television shows.
- They advocate for teen health issues at meetings and testify before local and state policy-making groups on teen issues.

Such presentations can take place in a number of school and community settings: at assemblies or in individual classrooms, in front of service organizations, in front of youth groups, and at conferences and hearings of policy-making bodies. PACT teens may also present skits that they have created on topical issues. Experience has shown that it is important that the teens themselves be involved in screening requests for presentations. Perhaps most important, PACT teens help young people in their communities with a range of information on an informal basis. Part of the training involves familiarizing PACT teens with services in the community so that they can refer peers to appropriate community-based agencies when necessary.

Teen Theater

Teen theater is sometimes an important component of peer education programs. It is a vehicle for educating young people about pertinent health issues and also provides them an opportunity to develop leadership skills. Many family life education courses and after-school programs incorporate skits and teen theater into their activities. Programs like the City Volunteer Corps (CVC) and WEATOC (We're Educators with A Touch of Class) use teen theater to focus on teen health issues and other teen concerns.

When the New York City Mayor's Office on Adolescent Pregnancy and Parenting developed its Peer Program for Middle Schools, it chose the CVC as the ideal collaborating partner for implementing the program. The CVC's original aim was to demonstrate that urban young people could make a positive contribution to their communities while making a successful transition to adulthood. Its drama group uses improvisational theater and peer advisors to educate middle grades youth on a range of health and related issues. After presentations, CVC members respond to questions from the audience first in character — that is, from the viewpoint of the character they portrayed in the skit — and then from their own experience.

WEATOC is a health education/sex education outreach program started in Boston in 1979. The program uses teen theater, peer counseling, and workshops to educate young people, parents, and professionals working with youth about relevant health and adolescent issues. WEATOC members are trained youth educators, who work with two adult coordinators.

Program performances provide information and present dramatic situations focusing on various topics, including teen pregnancy, birth control, AIDS, child-parent communication, sexually transmitted diseases, drug and alcohol abuse, and gang and domestic violence. Skits have included "The Wiz — The Untold Story," which focused on the problems of communication between parents and children; "Mr. and Mrs. Contraception"; and

"Double Standards," which examined the different socialization of sons and daughters, especially regarding sexuality. After each performance, WEATOC members lead discussions with the audiences about the issues presented. During these discussions, members of the audience may role-play or reenact portions of the skit.

WEATOC is a also model training program in health education. In an eight-week comprehensive training course, WEATOC peer educators and professionals instruct peer leaders in how to conduct reproductive health and sexuality workshops and in peer counseling. WEATOC offers a training component for youth workers on how to approach, engage, and be sensitive to young people.

Resources

Cook, Anne Thompson, Janet L. Sola, and Robin Pfeiffer. *PACT: Peer Education in Sexuality and Health*. New York: YWCA of the U.S.A., 1989.

> A training manual describing the basic components of a peer education/teen empowerment/training program including recruitment, training techniques and strategies, dealing with diversity, planning and administration, tailoring the program to the particular needs of a community, developing budgets, and fundraising. (Available from Network Publications, Santa Cruz, CA).

Myrick, Robert and Don Sorenson. *Peer Helping: A Practical Guide*. Minneapolis: Educational Media Corporation, 1988.

> Assists educators and youth workers in developing listening, responding and decision-making skills in teens.

Varenhorst, Barbara. *Curriculum Guide for Student Peer Counseling Training*. 1980.

> Fifteen 90-minute sessions to enable students to interact one-to-one with their peers. Curriculum covers basic skills for initiating conversations to developing more complex skills of observing nonverbal communication, communicating with adults, application of counseling skills to family problems, sexuality issues, and peer relations. (Available from the author at 350 Grove Drive, Portola Valley, CA 94025).

WEATOC: We're Educators with A Touch of Class, 118 Milk Street, Boston, MA 02109.

> A teen theater group and peer education training institute.

Notes

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2. D. H. Thornberg, "Adolescent Sources of Information on Sex," *Journal of School Health* (Vol. 51, 1981), as cited in Schinke (see note 1).
3. Anne Thompson Cook, Janet L. Sola and Robin Pfeiffer, *PACT: Peer Education in Sexuality and Health* (New York: YWCA of the USA, 1989).
4. Ibid.

5. Ibid.
6. Russell V. Luepker et al., "Prevention of Cigarette Smoking: Three-Year Follow-Up of an Educational Program for Youth," *Journal of Behavioral Medicine* (Vol. 6, No. 1, 1983).
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Chapter Ten

School-Based Clinics

> The clinic and the school are two different environments, each with a unique climate . . . . In this special relationship, a partnership develops which blends the two systems to improve the quality of life for adolescents.[1]

School-based clinics provide an excellent vehicle for collaborations between community-based agencies and schools. The number of school-based clinics offering a range of comprehensive services has grown in recent years, from 61 in 1984–85 to 178 in August 1990.[2] Support for school-based clinics has also increased. Public opinion polls in Michigan, Oregon, and North and South Carolina show that approximately 80 percent of adults support the establishment of school-based clinics; the strongest support is among parents of school-aged children.[3] A 1985 Harris poll found that 69 percent of a representative national sample supported laws allowing schools to establish linkages with clinics to provide contraception education and services.[4]

This support has resulted from concern about increased rates of pregnancy, substance abuse and sexually transmitted diseases, especially AIDS, among teenagers and from a growing awareness that increasing numbers of students suffer from undernourishment and poor health: nationally, 70 percent of teachers think that poor health and undernourishment are problems for their students.[5] The majority of school-based clinics are in high schools, but 21 operate in junior high and middle grades schools.[6] Typically, school-based clinics are run by public health departments, school systems, medical schools, hospitals, and community-based clinics and funded through a variety of sources, including the city and county, maternal and child health block grants, Medicaid, the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program and foundations.

School-based clinics serve all students enrolled in the school. In addition, approximately a third serve dropouts, students from other schools, and the children of students enrolled in the school. Male outreach is an important aspect of the work of most school-based clinics. In 1990, 44 percent of students using such clinics were male.[7] Rates of use are high: an average of 71 percent of students enroll and from 32 percent to 50 percent use the clinics.[8] Students cite a variety of reasons for using school-based clinics: they are convenient; services are confidential and inexpensive or free; and staff are caring.[9]

Nearly all clinics — 90 percent — require some form of parental consent, although the method of doing so varies. Of clinics requiring parental consent, 29 percent list the services requiring consent; 29 percent list all services and allow parents to designate those they do not want their children to receive; and 27 percent simply list all services. In addition, when state law permits, many clinics provide special services without parental consent: 47 per-

cent treat sexually transmitted diseases, and 43 percent offer family planning services without consent.[10] While few parents actively deny their consent for services, failure to return clinic enrollment forms can be a great barrier to clinic use.[11]

Services Available in School-Based Clinics

Most school-based clinics provide a full range of health and mental health services, including general primary care and physicals, immunizations, EPSDT screening, treatment of minor injuries and management of chronic illnesses. In addition, most clinics offer mental health counseling, nutrition education, and health and reproductive health education. Reproductive health accounts for an estimated 10–25 percent of the services provided by school-based clinics.[12] The proportion of clinics that offer contraceptive counseling and referrals rose from 20 percent in 1986 to 85 percent in 1989.[13] However, only 21 percent of clinics dispense contraception.[14]

Some clinics offer services that are not health-related. For example, New Jersey's School-Based Youth Service Centers provide a greater range of services to troubled adolescents and their families. In addition to a core of health and mental health services, they offer employment training and counseling and classes in parenting; provide child care; and undertake outreach to out-of-school youth.

School-Based Clinics and Controversy

One criticism leveled at school-based clinics that dispense or prescribe contraceptives is that they promote sexual activity among students. As with the similar charge aimed at sex education, this has not proven to be the case. An in-depth evaluation of six school-based clinics serving low-income populations revealed that clinics neither hasten the initiation of sexual activity nor increase the frequency of intercourse among sexually active students. None of the clinic schools studied had a significantly higher proportion of sexually active students than did comparison schools, nor did sexually active students in clinic schools have sex more frequently than did those in comparison schools. One clinic school had a smaller proportion of sexually active students; in two clinic schools, sexually active students reported having initiated sex at later ages than in comparison schools; and in one clinic school, sexually active students reported less frequent intercourse two years after the clinic opened than before.[15]

Despite such results, some controversy is probably inevitable in school districts planning to start school-based clinics. Many of the strategies for dealing with controversy, outlined in chapter 15 are applicable here. In particular, practitioners advise that school districts and community-based agencies planning a school-based clinic would be wise to undertake a survey on the issue so that when opposition arises, they can document support for clinics — especially among the families of school-aged children. Often the most virulent opposition turns out to be among people who have no children in the school system.

The Center for Population and Family Health School-Based Clinics

In 1986, the Center for Population and Family Health at Columbia University in New

York City began operating clinics in the first of four intermediate schools in Washington Heights, a low-income, primarily African American and Hispanic community. Schools in the community have the lowest ranking in reading achievement in the city; one in five adolescents in Washington Heights are drop outs; and the community's teen fertility rate is higher than that for the city as a whole. The long-range goals of the clinics were to effect a decrease in the pregnancy and dropout rates. The clinics offer two major types of services: comprehensive health services, including physicals, vision and hearing screening, treatment of minor illnesses, and immunizations; and comprehensive social support services, including psychosocial assessments, group, individual and family counseling, and referrals.

Clinic staff consist of a midlevel practitioner who performs physicals and screenings, treats minor illnesses and provides first aid; a health advocate who makes appointments and follows up on referrals for students; and at least two social workers. Staff are very visible in the school — in the hallways and cafeteria, and, in one school, in the classroom providing health education. Their visibility is apparently one of the major reasons for the clinics' success. According to the director of the project, clinic staff are very effective in reaching out to students because "they are not authority figures and are perceived by the kids as people who are truly concerned about their personal problems."[16]

Respect for the privacy of students is vital. Clinic staff assure students that information will not be shared with teachers and families unless staff fear that students may do something harmful — and in this case, staff inform the student first. Support for the program among parents has been strong: at the two schools where the first clinics were established, 75 percent and 67 percent of parents signed the consent form the first year, and the proportion increased in subsequent years.[17]

The clinics were designed to provide health and social support services addressing the needs of students and their families. However, it soon became clear that the program had to address students' educational needs and experiences, since these were a crucial part of the students' health and mental health. As a result, the Center initiated a basic skills remediation curriculum in an after-school program at one of the schools. However, this turned out to be too narrow in scope — both because it served only 40 students and because it did not affect the larger educational experience of the school population.

Consequently, in October 1988, one of the schools, Inwood Intermediate School 52, undertook an initiative designed to restructure its organizational and educational program to provide developmentally appropriate academic programming and practices and a range of health, guidance and other supports integrated into its daily functioning. This restructuring effort, which the Center funded and which had the full support of the principal and involved the Academy for Educational Development in providing technical assistance, has entailed organizing the school into "houses" designed to provide teachers and students with a sense of intimacy and to encourage flexibility of scheduling and programming. House teacher teams meet weekly to plan curricula and instructional activities and to consult on student-related issues. The restructuring plan has also included extensive staff development on age-appropriate curricula and innovative teaching strategies, and the establishment of a school-based management team and house leadership teams.

According to the director of the project, practitioners wishing to establish school-based

clinics must "start small . . . one school at a time . . . and with sufficient funds to provide comprehensive services. It takes time to become established and trusted, but the rewards are great."[18]

School-Linked Clinics

A variation on school-based clinics are school-linked clinics — which operate close to a school or several schools. School-linked clinics have several advantages:

- They can serve a number of schools. This is beneficial when a school district is small or when the chances are that a clinic in one school would be underutilized.
- They allow students using them anonymity.
- They give clinic staff more freedom to operate.

Programs operating school-linked clinics, however, may have to provide transportation for students — especially middle grades students.

The Johns Hopkins Pregnancy Prevention Program: The Self Center

The Self Center was a school-linked adolescent pregnancy prevention program run by Johns Hopkins School of Medicine in collaboration with the Baltimore City school system. The program, which served two schools — an inner-city junior high school and a senior high school — was based on the belief that effective pregnancy prevention must include education, family planning services and supplies, and counseling. It operated both in the schools and in an adjacent clinic — located across from the senior high school and four blocks from the junior high school — with staff shared between the sites.

Center staff — a social worker and nurse for each school — made sex education presentations at assemblies and in individual classes, ran individual and group counseling sessions, and conducted staff development. Staff spent 2–3 hours during the middle of the day in the school health suite, where they provided individual and group counseling. Students, whom clinic staff trained as "peer resources" served as counselors and publicized the availability of the clinic services. The program's medical services included contraceptive counseling, pregnancy tests, and diagnosis and treatment of sexually transmitted diseases. The clinic dispensed contraceptive foam and condoms to both male and female students after providing counseling on their proper use.[19]

Psychosocial counseling was an important aspect of both the school-based and the clinic components of the program. A major emphasis was on developing future goals and on "making a life for oneself before making another life (hence the name)."[20] Staff also stressed the importance of developing values and communicating with parents. Although nonjudgmental in their attitudes, staff made it clear to students that early onset of sexual activity was not in their best interest. They encouraged sexually active students to use contraception consistently.

Rigorous evaluation results of the program were positive. Pregnancy rates for students in grades 9–12 who were exposed to the program for 28 months decreased by 30 per-

cent, while a control school's pregnancy rate rose 58 percent. Over the same period, small reductions apparently occurred in the pregnancy rates of students under 15, but these were difficult to evaluate because numbers were so small. The program also delayed the average age of onset of sexual activity by seven months. The evaluation concluded that the clinic's high visibility, its free services and proximity, and the caring and involved staff, rather than any "new" information about contraception, "allowed teenagers to translate their attitudes into constructive preventive behavior."[21]

The Self Center is now the Community Adolescent Health Center and offers comprehensive health services to Baltimore teens aged 10–15.

Resources

Hadley, Elaine M., Sharon R. Lovick, and Douglas Kirby. *School-Based Health Clinics: A Guide to Implementing Programs*. Washington DC: Support Center for School-Based Clinics/Center for Population Options, 1986.

> An in-depth guide covering every step in establishing a school-based clinic: assessing need; selecting a site: building community support; designing the clinic; obtaining funding; selecting staff, and evaluation.

The Center for Population and Family Health, 60 Haven Avenue, New York, NY 10032.

> Operates school-based clinics in four intermediate schools in New York.

Notes

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3. Center for Population Options, *School-Based Clinics Enter the '90s: Update, Evaluation and Future Challenges* (Washington, DC: Center for Population Options, 1989).
4. Louis Harris Associates, "Public Attitudes About Sex Education, Family Planning and Abortion in the United States," Study No. 854005, 1985, as cited in Joy G. Dryfoos, "School-Based Health Clinics: Three Years of Experience," *Family Planning Perspectives* (Vol. 20, No. 4, July/Aug. 1988).
5. Carnegie Foundation for the Advancement of Teaching, *The Condition of Teaching: A State-by-State Analysis* (Princeton:NJ: Princeton University Press, 1988) as cited in Carnegie Council on Adolescent Development, *Turning Points: Preparing American Youth for the 21st Century* (New York: Carnegie Corporation, 1989).
6. Hyche-Williams and Waszak (see note 1).
7. Ibid.
8. S. G. Millstein, *The Potential of School-Linked Centers to Promote Adolescent Health and Development* (Washington, DC: Carnegie Council on Adolescent Development, 1988), as cited in Carnegie Council (see note 5).
9. Center for Population Options (see note 3).
10. Hyche-Williams and Waszak (see note 1).
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17. Ibid.
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19. Laurie S. Zabin et al., "The Baltimore Pregnancy Prevention Program for Urban Teenagers," *Family Planning Perspectives* (Vol. 20, No. 4, July/Aug. 1988).
20. Laurie S. Zabin and Marilyn B. Hirsch, *Evaluation of Pregnancy Programs in the School Context* (Lexington, MA: Lexington Books, 1988).

Chapter Eleven

Service Learning

> Adolescents who help to care for young children, who assist people with disabilities, . . . tutor their peers or younger children, visit with the aging . . . organize an action campaign to rehabilitate a building . . . clean up a stream or advocate for the homeless are filling a void that our age of technology and alienation has created in their lives. Perhaps in more positive ways than their counterparts of an earlier era, they are assuming meaningful roles and responding to real needs of their society as well as their own need to be needed.[1]

Service learning is an increasingly important component of middle grades education and of risk prevention programming. For example, it is a key aspect of the Teen Outreach Program (described in Chapter 13).

Service learning programs are based on a growing understanding of the importance of meaningful work in giving young people a sense of self-worth and of competence. While young adolescents in the past often had to work in the factory or on the farm, our increasingly urban and technological society has denied young people "the opportunity to be engaged in work that is important to others" and therefore denied them "the rewards such work produces."[2]

Service learning programs recognize both the need that young adolescents have to feel useful and their capacity for making a positive contribution to the community. Further, involvement in service learning can meet many of the special needs of early adolescents that chapter 2 describes. Some of these needs are to

- Develop a sense of competence
- Have their opinions valued
- Participate in projects with visible outcomes and receive recognition for their accomplishments
- Have opportunities to make real decisions, within appropriate limits
- Develop a sense of future options
- Be exposed to and receive support from a variety of adult role models
- Have the freedom to both take part in the world of adults and to retreat to the world of their peers[3]

Typically, young people involved in service learning programs work with the elderly in community-based senior citizen centers and nursing homes, help people with disabilities,

visit people confined to the home, tutor their peers or younger children, work in soup kitchens, or work with young children in Head Start programs and day care centers. Sometimes, young people work in groups doing neighborhood cleanups and helping with construction projects, taking children in homeless shelters on outings, serving as mentors for children in foster care, building playgrounds for day care centers, and distributing food after a hurricane. Youth have also taken on communitywide problems, participating in drug awareness and pregnancy prevention programs and advocating for the homeless.

It is not sufficient merely to provide young people with opportunities for service learning. The success of the experience depends in large part on a number of other important factors: "the type of service, the way the young person is received at the placement site, and the kinds of tasks and responsibilities he or she assumes . . . are among the factors that will determine the power of the experience."[4] A process evaluation of the Teen Outreach Program, suggested that "the extent to which the volunteer service engages student interest, pride and commitment" is the most important factor in determining its success.[5] Also important are the preparation that young people receive for their work and the ongoing opportunities that programs give them to reflect on and share their experiences.

Whatever type of work young people are engaged in, it is important that the task "be real — not busy work that regular staff want to avoid."[6] One-shot or stand-alone experiences — such as collecting food for famine relief or working in a soup kitchen at Christmas — while not without worth and impact, are less desirable than ongoing experiences.

The Advantages of Service Learning

For young people involved, service learning has many advantages beyond the feelings of self-worth and accomplishment they gain from doing a job well. It provides opportunities for career exploration and for developing work habits and attitudes:

> It challenges the volunteer to work collegially with others, to learn to compromise and to communicate successfully. It encourages the acquisition and exercise of new skills. It presents "real world" opportunities to confront problems, consider alternatives, and find solutions.[7]

Another advantage of service learning is its curriculum potential. If properly done, service learning experiences can be integrated into the classroom curriculum in ways that enhance learning and impress upon young people that what they learn in the classroom is relevant to the world of work. Sometimes, a volunteer experience can give rise to a topic for the classroom: the changes in the family, human growth and development, child development, the immigrant experience. Young people's reading, speaking, and listening skills improve when they record oral histories or read to preschoolers. Mathematics skills can be incorporated into a neighborhood improvement project. Writing logs or journals can help young people gain insights about the volunteer experience, while at the same time developing their language skills.

Several school systems have made service learning part of their programming. In Maryland, for example, high schools are required to offer service learning for credit. The

middle grades have relatively few service learning programs — the Teen Outreach Program is one notable exception; another is the Early Adolescent Helper Program described below.

The Early Adolescent Helper Program

Service learning is the core of the Early Adolescent Helper Program. The National Commission on Resources for Youth established this program of the Center for Advanced Study in Education at the City University of New York in 1982–3 in three New York City intermediate and junior high schools. The program targets inner-city poor and minority youth who have limited opportunities to be active participants in their communities and places them as helpers in community agencies such as child care and senior citizens centers or in pre-kindergarten through third grade classes in their own school. Young Helpers take part in a variety of activities. In child care centers, they may supervise children in the playground, assist at snack time, take part in music or arts and crafts activities, and read with the children. In senior citizen centers, seniors and Helpers become partners, recording oral histories, collaborating on arts projects, and forging intergenerational links.

Young Helpers also participate in a weekly small group seminar that both prepares them for their work and helps them reflect on and learn from the experience. A program leader — usually a teacher or guidance counselor — conducts these sessions. Initially, sessions train Helpers to deal with the particular population with which they will work. Once Helpers are placed, these sessions assist them in dealing with issues that arise at the worksite:

> Sessions help participants develop listening skills, assume responsibility, meet new people, and exercise authority — something they have often had little experience in doing. — Coordinator, middle grades service learning program

Sessions also provide Helpers with information on topics like parenting and human development, work behavior, dress, and attitudes, as well as offering preemployment and career exploration activities.

Helpers receive no pay for their work, but program staff encourage helpers to view their experience as they would paid jobs. An annual convention recognizes their contribution and allows Helpers to meet and share experiences. An evaluation of the program showed that Helpers changed their attitudes to discipline and "developed more realistic views of children." The evaluation also noted that the program has been "an important vehicle for establishing or improving communication between participating agencies and schools."[5]

Conclusion

Service learning is not primarily a pregnancy prevention strategy. However, given the role that this approach can play in enhancing young people's sense of competence and increasing their motivation to avoid too-early pregnancy — by giving them both a sense of possible work options and a more realistic idea of what is involved in taking care of children — service learning can clearly be a vital component of pregnancy and risk prevention programming.

Resources

National Center for Service Learning in Early Adolescence, Center for Advanced Study in Education, Graduate School and University Center of the City University of New York, 25 West 42 Street, New York, NY 10036.

Established by the Early Adolescent Helper Program, the Center offers a broad range of services to school districts and agencies interested in initiating service learning programs; it also collects and dispenses information on service learning program models, conducts research on service learning and its impact on adolescents, and advocates locally and nationally for service learning programs in the middle grades.

Notes

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Chapter Twelve

Mentoring

> Being a mentor is a chance to be a positive influence, a chance to give back something to my culture and community. — Mentor
>
> Having a mentor gives me someone older to help me with my work, to give me the facts, to tell it like it is. — Mentee

Mentoring is an important component of many pregnancy prevention programs — and of programs to reduce risk behavior in general. It seems a particularly appropriate strategy with early adolescents, given that at this age, young people are beginning to look beyond the family for supportive and caring relationships with adults. Research has indicated that the young people who succeed, despite many seemingly insurmountable barriers, are those who have a positive relationship with a parent or who have been able to forge such a relationship with another adult:

> Among poor children from the inner cities, those who cope well . . . have at least one significant positive adult role model, not necessarily the parent. The existence of additional caretakers and social supports is particularly influential in a single-parent household where resources are few.[1]

Many young people forge such relationships informally — seeking out concerned teachers, counselors, or neighbors. Mentoring programs seek to ensure that young people at risk have at least one caring and supportive adult in their lives.

The purposes of mentoring programs are varied. Some programs provide young people with positive role models — responsible and caring adults to whom they can relate on a one-to-one basis. The Atlanta UMSAPPP project initially paired African American middle grades boys, many of whom were being raised by single mothers, with African American males recruited from various colleges, fraternities, and businesses. "The chief goal of our mentor program," the project director explained, "was to give students a constant caring relationship with a man who could give them a sense of direction." Other programs seek to broaden student exposure to the world of work and to help students develop work-readiness skills and attitudes:

> We want our students to have a sense that there are career options for them, so we pair them up with African American professionals. The mentors take the kids to their place of work and talk to them about the importance of doing well in school. — Mentor program coordinator

Some programs focus on widening students' educational horizons by pairing them with college students from the same background. In the UMSAPPP project at Hollenbeck

Junior High School in Los Angeles, for examples, mentors were college students who had grown up in their mentees' community. Mentors took their students to the California State campus for events and weekend activities "to show them that there were people just like them who were in college." The main purpose of other mentor programs is academic enhancement and dropout prevention. Mentors are an important component of Public/Private Ventures' (P/PV) Summer Training and Education Program (STEP), a program aimed at 14–15-year-olds who are having trouble academically. The program pairs students with mentor-advocates who meet regularly with them, monitor their academic achievement, and either tutor the students or arrange for tutorials.

Many mentor programs have a number of goals. Whatever the specific goals, most practitioners involved in mentor programs agree that mentors can play a vital role in supporting young people through the early adolescent years and, specifically, in encouraging them to set educational and noneducational goals for themselves. Practitioners advise, however, that it is important to be aware of what mentors do not do. Above all, one mentor cautioned, mentors must avoid the "savior syndrome":

> Remember your goal is not to rescue kids; rather you are there to be a role model and help them develop skills for effective living.[2]

Nor is it realistic to think that mentees will discuss all their problems with their mentors — especially at first:

> The expectation that a mentee will "tell all" is unrealistic and places a heavy burden on a relationship. Such communication should not be the primary measure of success in a relationship.[3]

What Do Young People and Mentors Do Together?

Depending on the focus of the program, mentor-mentee activities vary. Mentors and young people can attend sports and cultural activities together, work on school projects, or attend jobs fairs and college orientation sessions. When mentoring is part of a pregnancy prevention program, mentors can take an active role in helping young people be sexually responsible. However, mentors and mentees do not always have to be doing something:

> Sometimes my mentor and I just take a walk and talk about the week. Or we just hang out together. . . . She's shown me that there are lot of safe ways to have fun and things that you can do that don't cost a lot of money. — Mentee

How Are Mentors Recruited?

Methods for recruiting mentors vary. Programs may recruit mentors through local colleges, fraternities or business organizations (for example, the Chamber of Commerce), or local companies. Experience indicates that it is best if a local community-based organization — a church group, a college, a civic organization, or a business — assumes responsibility for recruiting and orienting mentors and for facilitating the program. A mentor program can be an ideal collaborative activity between schools or community-based organizations

with access to at-risk youth and local businesses, industries, and colleges with access to potential mentors.

Some programs — the Montgomery County, Maryland, Serving as Guides in Education (SAGE) model is an example — recruit mentors from the staff within each school. This model ensures that "someone in that building loves that kid." The advantage to this approach, one teacher asserted, is that "it can have a very positive effect on school climate: the school becomes a family." However, in some programs, having mentors from within the school may not be appropriate because, as one UMSAPPP project director explained: "People in the school are used to acting in a disciplinary capacity. It's hard for them to give this up. We want mentors to be primarily friends."

No particular age is ideal for mentors; the age of the people recruited may be a function of the program's specific goal. If the major aim of a program is to encourage at-risk youth to broaden their educational horizons, it may recruit local college students. At Spellman College in Atlanta, being a mentor is now a requirement of all sophomores. Middle-aged adults well established in a career may be appropriate mentors if the program is primarily career-oriented. Some programs — P/PV's Partner's in Growth, for instance — have used senior citizen mentors with success. A P/PV study of its mentor program suggests that adults who have had difficult lives and who have surmounted many problems may be the most effective mentors for at-risk youth.[4] Sometimes mentors receive a small stipend — as in the P/PV program; more often, mentors are volunteers.

Above all, mentors must be caring, concerned adults who like young people and are prepared to make the emotional and time commitment that a successful mentoring relationship requires. And, mentors must be accepting and must communicate that to their mentees:

> For many young people, the greatest fear is that the mentor will be part of the great adult conspiracy to take away their freedom, their creativity, their sense of wonder about life.[5]

> I was afraid my mentor was going to be just another adult to tell me all the things I'm doing wrong, but it didn't turn out that way. My mentor has really given me a sense that I am somebody. — Mentee

Adequate screening is a vital part of a good mentoring program. Most organizations have developed a process based on the particular goals of their program. Mentors and mentees are sometimes matched on the basis of gender and race/ethnicity; sometimes not. Orientation is an important aspect of the mentor program. Mentors must understand the goals both of the mentor program and of the pregnancy prevention or risk prevention effort of which it is part. They also need training in ways to work effectively with students and families in helping their mentees deal with conflict positively and in recognizing when a mentee may have problems in the home that call for professional intervention. A program must include mechanisms for frequent communication between mentors and school or agency staff. Mentors also need ongoing support to deal with problems that arise and opportunities to share experiences with other mentors.

Issues of Diversity

A major barrier that could affect the mentor-mentee relationship is the "culture shock" that both mentor and mentee may experience as they encounter differences deriving from race, ethnicity, class, gender, religion, or culture. Differences may be evident in communication patterns and body language; different attitudes to authority, the family, gender roles, sexuality; or in ways of solving conflict.

Perhaps one of the biggest barriers that mentor programs must deal with are the barriers that exist between youth culture and adult culture. Among others, differences of dress and language can create barriers to communication:

> I had to understand that beneath the funny hairdo, the chains, and the sullen attitude was a scared kid who wanted to be loved; and he had to realize that although I was never going to be hip, I was really an okay kind of guy. — Mentor

It is crucial for mentors to be respectful and nonjudgmental of such differences, even though this is sometimes difficult:

> I was appalled that my mentee always spent all the money she earned on frivolous things. I almost gave her the same lecture on thrift that my father had given me, until I reminded myself that nothing in her experience had shown her the advantages of saving. So I took a giant step back and introduced the notion of saving a little for the future very slowly. — Mentor

On the other hand, it is important not to "overrespond" to some issues and allow mentees to use cultural differences to excuse particular behavior. For example, however explicable lateness may be in terms of culturally different attitudes to time, a successful mentor-mentee relationship will be impossible if the mentee is chronically late. One mentor advised that such moments provide "real opportunities to talk about differences in an open way and to establish mutual expectations."

Those involved in mentoring programs speak of the importance of involving families as much as possible — both to enhance the program's effectiveness and to minimize difficulties that may arise because of racial, ethnic, and cultural differences. Parents and other family members may be initially suspicious of mentors, fearful that they will encourage in their children behavior that is at odds with what the family's community deems acceptable. In some mentoring programs, mentors meet with families — initially and on an ongoing basis.

Each One/Reach One

New Concept Development Center, a comprehensive social service agency in Milwaukee with a variety of programs for youth, initiated the Each One/Reach One mentor/role model program in 1982. The major goals of Each One/Reach One are to help young people stay in school and avoid risk behaviors and teen pregnancy by exposing them to positive role models and alternative life styles. The program serves youth aged 7–13 from two Milwaukee housing projects and their families. It matches youth with minority professionals recruited from educational institutions, businesses and professional organizations. Mentors meet with their youth an average of 10 hours a month, helping them with home-

work and school projects; taking them to their place of work; and going to plays, museums, and other cultural events. The goal is for mentors to share the "secrets of their success" with the young people and establish supportive and encouraging relationships with both the young people and their families.

Youth also attend weekly group counseling sessions focusing on sexuality, decision making and setting educational goals. Peer counselors — local high school students — help facilitate these sessions. Each One/Reach One also provides individual counseling as needed and career education classes, taught by minority professionals. The program has a parents advisory group, which meets quarterly to assist in program planning and with special projects.

Each One/Reach One has undergone no formal evaluation. However, of the 200 young women who have participated since 1982, only three have become teen mothers. All Each/One Reach One participants have graduated from high school and gone on to postsecondary education, the military, or employment.

Resources

Big Brothers/Big Sisters of America, 230 North 13 Street, Philadelphia, PA 19107.

> Provides young people with positive role models as mentors, friends, listeners. Volunteers spend time each week with their mentees and receive special instruction on being a positive influence while being sensitive to parental guidelines. There are approximately 500 affiliates nationwide.

Each One/Reach One, New Concept Development Center, 636 West Kneeland Street, Milwaukee, WI 53212.

> Mentor/role model program run by New Concept Development Center. New Concept is establishing a training institute through which to train organizations interested in the mentor/role model approach.

National Media Outreach Center. *Milestones in Mentoring*. Minneapolis: QED Communications, 1990.

> A video and guidebook produced by the National Media Outreach Center, in conjunction with BUDDY SYSTEM, a division of the Minneapolis Youth Trust. Provides introduction to many of the issues involved in being a mentor; units include Getting Started, Respectful Confrontation, Dealing with Diversity and Troubled Families. (Available from ONE PLUS ONE, P.O. Box INFO, Pittsburgh, PA 15213.)

Notes

1. Carnegie Council on Adolescent Development, "Adolescence: Path to a Productive Life or a Diminished Future?" *Carnegie Quarterly* (Vol.35, No. 1, 2, Winter/Spring, 1990).
2. National Media Outreach Center, *Guidebook for Milestones in Mentoring* (Minneapolis: QED Communications, 1990).
3. Ibid.
4. Freedman, Marc, *Partners in Growth: Elder Mentors and At-Risk Youth* (Philadelphia: Public/Private Ventures, 1988).
5. National Media Outreach Center (see note 2).

Chapter Thirteen

Putting It All Together: Multicomponent Programs

The three pregnancy prevention programs described in this chapter take a multifaceted approach to pregnancy prevention by providing young people with a range of programs and activities to help them develop both the capacity and the motivation to avoid too-early sexual activity, pregnancy and parenthood.

Teen Outreach Program

The Teen Outreach Program (TOP) is a school-based primary prevention program premised on the belief that teens with positive experiences in the community and the opportunities to discuss life options with a responsible adult will be more likely than others to complete school and to defer parenthood. The program's two major goals are to reduce adolescent pregnancy rates and increase school completion rates.

The St. Louis Junior League started TOP in 1978; the nationwide demonstration phase began in 1984. The Association of Junior Leagues International now runs TOP which operates in 108 sites in 39 communities, both urban and rural. Teen Outreach received a citation from the National Research Council as one of the only school-based, noncontraceptive focused pregnancy prevention programs able to document its positive impact.[1]

Teen Outreach has two major components. The first entails weekly group discussions and counseling, using a curriculum focusing on life management skills, career planning, substance abuse, self-esteem building, child abuse and sexuality. These sessions are led by a teacher/facilitator. The group experience allows participants to interact with a positive adult role model who is not an authority figure; it also provides them opportunities to think critically about relevant issues and to evaluate their own behavior and attitudes. In these sessions, the emphasis is on encouraging students to set personal and educational goals. The group dynamic is essential to the success of the program:

> Above all, the group must be a place where young people can feel secure in expressing their thoughts and feelings and able to make mistakes. The students learn to express their feelings and are given constructive feedback; they learn to work together as a group, to establish rules that group members must follow, and to discuss and solve problems as a group. — TOP coordinator

TOP's second component is volunteer service/service learning: teens work once a week in such community agencies as child care and day care centers, nursing homes and senior citizen centers, hospitals, and recreation centers. This component is based partially on the

"helper-therapy" principle[2] which suggests that "helping other people can be therapeutic and can lead to personal growth, especially for persons in disempowered groups. A sense of empowerment is engendered by placing them in help-giving rather than help-seeking roles."[3] The volunteer component helps to show students that they can make a positive contribution to their community, that they have something worthwhile to offer. As one Teen Outreach participant expressed it: "The volunteer work proves to me that I am needed — that I can make a difference." Through TOP's volunteer compenent, young people also develop supportive relationships with adults in their communities and can begin to explore future work options.

Teen Outreach serves a mixed population. In the 1988–9 school year, 70 percent of the students were girls. Overall 40 percent were African American, 40 percent white, and 13 percent Hispanic. Some 41 percent came from non-intact families; 20 percent had mothers with less than a high school education, and 30 percent had mothers who attended college. The program has been equally successful with students from a variety of racial and socioeconomic backgrounds, but appears to benefit students from single-parent families even more than those from two parent families.

While TOP began as a program for high school students, approximately half of the schools now involved are middle grades schools. The average age of a Teen Outreach student is 14.9. In the middle grades schools, the volunteer service is often of a group nature: teens help clean up a playground; organize and participate in an AIDS walk; or volunteer in a soup kitchen or in a homeless shelter.

Certain aspects of the program — like scheduling and recruitment — vary from site to site. In some schools, Teen Outreach is offered during the school day; in others, after school. In some schools, students receive credit while in the program; in other schools, they do not. In some, students volunteer for the program; in others, students considered at high risk of dropping out are placed in the program.

Teen Outreach exemplifies a successful collaboration between schools and community-based agencies. All Teen Outreach programs have a local sponsor, often a Junior League affiliate. The sponsor secures funding for the program, arranges and monitors the volunteer component, and collaborates with the school system.

Rigorous evaluation is an important component of Teen Outreach. For five years, facilitators at all TOP sites were required to collect baseline and outcome data for all participants and a control group, chosen by random assignment, or comparison group, chosen through a process that identified students whose backgrounds and attitudes were similar to Teen Outreach students. A computerized data base of student characteristics, baseline risk measures, and outcome data was kept for both groups. Evaluation results were impressive. In the four years ending in 1988, Teen Outreach students had an 8 percent lower rate of course failure, 16 percent lower rate of school suspensions, 36 percent lower rate of school dropout, and 42 percent lower rate of pregnancy than control or comparison group students. The Teen Outreach evaluation model is available for other pregnancy prevention programs to use or adapt.

Teen Outreach is entering a replication/institutionalization phase, in which ways to implement the program at the state and community levels will be developed. A middle

grades and a high school model will be developed for each level. Central to this replication phase is an ongoing process evaluation that seeks to identify the "active ingredients" of the program — those that are essential for successful replication. Process evaluation will also seek to determine what aspects of the volunteer component are most likely to promote positive change.

The Children's Aid Society Adolescent Sexuality and Pregnancy Prevention Program

The Children's Aid Society of New York's Adolescent Sexuality and Pregnancy Prevention Program is a non-school-based comprehensive pregnancy prevention program. It operates in three Children's Aid Society community centers in Harlem and offers teens and their families a full range of activities and services. The program's message, according to its director, is not "Don't have babies," but "Don't have babies until you are ready, until you have a career, until you can be a responsible parent."[4]

This program has eight components:

- *Family life and sex education*: a 15-week program, with separate units for parents and teens, that presents a holistic view of sexuality as encompassing body image, gender role, social roles, relationships, and intimacy. At the completion of the course, participants have a graduation ceremony.
- *On-site primary health services*: complete physical examinations, contraceptive counseling, and prescriptions; weekly follow-up of contraceptive patients.
- *Skills training in individual sports*: squash, tennis, golf, and swimming. These skills emphasize self-discipline and self-control. Program planners hope that young people can transfer the skills mastered in these sports to other aspects of their lives.
- *Academic assessment and homework help*: complete educational needs assessment and individual and group tutorials, given by volunteers and educational experts.
- *College admission program*: the program guarantees every teen and parent participant a place as a freshman at Hunter College (part of the City University of New York) with all costs subsidized, if the young person participates in the teen pregnancy prevention program and graduates from high school or completes a GED.
- *Self-esteem enhancement through the performing arts*: weekly workshops with parents and teens led by professionals from the National Black Theater and other theater professionals. Issues covered include conflict resolution, school experiences, job problems, family roles, gender roles, and racism.
- *Job club and career awareness program*: employment specialists conduct weekly sessions to explore career possibilities and help teens secure a social security card, complete working papers, and apply for jobs. Each teen secures a paid job or takes part in an Entrepreneurial Apprenticeship Program. Each participant opens a bank account and contributes to it monthly.
- *Individual counseling*: focusing on decision making and on family, peer, and school

issues. Clinical staff or the Children's Aid Society mental health program handle serious problems.

Involving families is an important aspect of the program's work. The program involves parents in many services — sex education, the job components, the theater — but in a separate track, to reserve the teens' confidentiality.

Only descriptive evaluation results are available. Since the program began in 1985, 265 teens and 110 parents have participated. Six girls have become pregnant, and two boys have fathered a child. Fewer than 10 percent of the participants have dropped out of school, a much lower rate than that in the Harlem community where the program is located. A number of graduates are enrolled at Hunter College (12 teens and eight parents).

The Children's Aid Society runs the Bernice and Milton Stern National Training Center for Adolescent Sexuality and Family Life Education, which offers intensive training to social services and youth-serving institutions interested in establishing similar programs. As a result of the first training session in 1990, 15 communities are replicating the Children's Aid Society Adolescent Sexuality and Pregnancy Prevention model in a variety of forms. In September 1991, 15 agencies from the New York City area will receive training to initiate programs of their own.

Summer Training and Education Program

Public/Private Ventures (P/PV) implemented the Summer Training and Education Program (STEP), a demonstration model, in 1985 in five cities. P/PV designed STEP for economically disadvantaged youth and built upon the federal Summer Youth Employment and Training program. Its primary goal was to prevent school dropout by reducing learning loss over the summer, enhancing reading and math skills, and reducing teen pregnancy. In 1990, STEP was operative in 68 sites in 14 states with support from the Department of Labor. STEP provides an excellent example "that teen parenting issues can be successfully addressed in the context of employment and training and education initiatives"[5] — services that have traditionally taken place independent of each other.

The program offers youth two summers of half-time work and half-time basic skills remediation and life skills instruction, and in-school support. STEP students work in a variety of single placements or group projects: as aides in day camps and day care centers; in parks and recreation programs; and in social service agencies, libraries, and radio stations. The math and reading remediation employs materials relevant to youth experience. In addition, the Practical Academies curriculum offers students specially developed teaching modules and computer-assisted instruction to enhance higher-order thinking skills.

STEP students receive instruction in life skills through the program's Life Skills and Opportunities curriculum, which emphasizes the importance of responsible social and sexual behavior and seeks to give young people confidence in their ability to plan for the future and make responsible choices. The curriculum includes a visit to a family planning clinic. During the school year, STEP also offers young people a range of supports to help them remain engaged in the learning process. In particular, STEP youth meet regularly

with advocates who refer them for needed services and arrange for tutoring and other remedial supports.

In 1990, over 1,300 students in grades 7–10 were enrolled in STEP; 55 percent of them were males. Some 62 percent of the youth were 14 years old; the others were 15. In all, 72 percent of students were from racial minority groups. Over half of students were at least one grade behind in school.

Evaluation results from the demonstration and replication sites have shown that STEP students did not "lose ground" over the summer academically, as control group students did; STEP students also showed gains in both reading and math and increased knowledge of how teen parenting can affect their life choices. Long-term follow-up is under way to determine whether participation in STEP reduces the incidence of teen pregnancy.

Resources

The Children's Aid Society National Adolescent Sexuality Training Center, 350 East 88 Street, New York, NY 10128.

> A training center for community-based agencies and youth-serving organizations wishing to implement pregnancy prevention programming.

Teen Outreach Program, Association of Junior Leagues International, 660 First Avenue, New York, NY 10016-3241.

> Has several publications that are useful to educators and practitioners seeking to initiate pregnancy prevention in the middle grades: *Teen Outreach: How-To Manual; The Teen Outreach Program: A Guide and Curriculum for Facilitators;* and *Teen Outreach: How to Participate in the National Evaluation.*

Summer Training and Education Program (STEP) Public/Private Ventures, 399 Market Street, Philadelphia, PA 19106.

> Available for use by school districts and communities on a competitive basis. P/PV assists in the organization, management, and delivery of the program; provides staff development and offers on-site technical assistance.

Notes

1. Cheryl D. Hayes, *Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing*, Vol. 1 (Washington DC: National Academy Press, 1987).
2. F. Riessman, "The Helper Therapy Principle," *Social Work*, 10, 1965.
3. Association of Junior Leagues International, *Teen Outreach Program: A Three-Year Proposal for Replication/Institutionalization* (New York: Association of Junior Leagues International, 1991).
4. Adolescent Pregnancy Prevention Clearinghouse, *Model Programs: Preventing Adolescent Pregnancy and Building Youth Self-Sufficiency* (Washington DC: Children's Defense Fund, 1986).
5. Summer Training and Education Program, *Teaching Life Skills in Context* (Philadelphia: Public/Private Ventures, 1989).

PART THREE

IMPLEMENTATION

Chapter Fourteen

Planning A Program

Planning collaborative pregnancy prevention activities in the middle grades includes several important steps. Ideally, there will be a year-long planning period supported by small grants from local foundations or corporations. Planners should use this time not only to establish the program's aims and approaches, but also to build support for it among educators, parents, and the community at large.

Building Support

Building support for the program is an essential task during the planning period. Planners should call a meeting of individuals and agencies that are likely to be key to successful implementation. These would include middle school principals, school district officials concerned with dropout prevention and risk behavior prevention, key individuals from community agencies serving youth, representatives from parent groups, and representatives of business or industry interested in working with schools on youth issues. Experience suggests that the support of the principal is essential for the successful implementation of pregnancy prevention activities targeted to middle grades youth. As one middle school family life teacher said, "When the principal buys into the program, it works."

To build support for the program in the community at large, a group of key agencies and the schools could host a community speak-out. In Atlanta, during the planning period, the UMSAPPP project organized a meeting that involved 105 agencies. Planners may ask community-based groups with standing in the community, like the Urban League, to convene a meeting to raise the issues. Building support for a program, both among educators and community-based agencies and in the community, is one of the most effective ways to prepare for controversy. (Chapter 15 discusses effective strategies for doing this.) Building support will create a "climate of ownership" among the various parties involved in the planning stages who will support the program when difficulties arise.

Assessing Needs and Available Resources

An assessment of a particular community's or school district's need is essential before planning can begin. What are the problems in the school and community related to sexual activity? Are middle grades students sexually active? Are those who are sexually active using contraception? How are they obtaining it? Do other factors indicate need: high rates of class cutting, school failure, school dropout, or substance abuse; and/or large numbers of students from poor or single-parent families? Are particular groups of youth at especially high risk?

Likewise, it is important to determine what programs and agencies for meeting the need already exist in the community. Do the schools offer family life education? In how many grades? Do after-school programs in community-based agencies provide remediation and counseling? Can one of these help determine the need — for example, a clinic with statistics about rates of use by middle-school-aged children? Besides the schools, what are the likely partners among community-based youth-serving organizations?

Determining the Program Goals

A program goal is the "general task to be achieved."[1] Program goals are based on need and on what services and programs already exist. For example, if no family life/sex education is available in a particular school or district, an obvious goal could be to implement family life education in the middle grades. If, on the other hand, a family life curriculum is in place, a program may focus on strategies and activities to strengthen its pregnancy prevention component and widen its impact.

In Boston, before the UMSAPPP project began, the middle schools offered no family life/sex education curricula at all — and the implementation of such a curriculum became one of the project's major goals. In Atlanta, on the other hand, an extensive family life curriculum was in place. The UMSAPPP project undertook the strengthening of the prevention aspects of this curriculum with small group counseling and mentors for at-risk youth. Similarly, in Milwaukee the UMSAPPP project undertook the enhancement of the human growth and development curriculum through extensive staff development focusing on pregnancy prevention.

Planning the Process

Planning the process — or determining process objectives — entails deciding what a program staff will do or what activities and services a program will provide to achieve the overall goal. How many times will the course meet? How many outside speakers, trips, counseling sessions, sessions with parents will the program offer? How many mentors and students will be matched? What staff development will be involved? How many meetings of the collaborating agencies will take place? Having a carefully planned process, even if it has to be modified, will be invaluable as implementation progresses, when time for planning will be limited. It can also be an invaluable tool in assessing the program: "The process objectives are the blueprints for action — the game plan."[2]

Determining the target population

It is important to decide early, on the basis of the needs assessment, who the major participants in the program will be. Should the target population be defined broadly — for example, the entire seventh-grade population? Or more narrowly — those seventh-grade students at high risk? And what will define risk — class failure? low grade point average? truancy? teacher recommendation? family socioeconomic status? All members of the collaborations should agree on these criteria. Having these criteria clear — and probably written down — will help to defend the basis for determining eligibility for involvement in

a program or a set of activities should the need arise. Also, in case of failure, carefully delineated criteria will help identify criteria for selection the program should have chosen.

Determining Program Objectives

A program's *objectives* (as opposed to its *goals*) are its hoped-for results in terms of participant knowledge and behavior. It is important to distinguish between a program's short- and long-term objectives: its outcomes and its impacts.

Outcome objectives are a program's short-term effects on participants — in other words, what participants will do or know as a result of the program. Will they know more about human reproduction — specifically will they be able to identify the time when the risk of pregnancy is the greatest? Will students be better able to communicate their feelings about sex? Will they be better able to resist peer pressure?

Impact objectives are a program's long-term effects on participants. The main impact objectives of a pregnancy prevention program in the middle grades could be to delay initiation of sexual activity and to increase contraceptive use among sexually active students. Other possible impact objectives could be to reduce class cutting and improve grade point averages.

In setting outcome and impact objectives, it is wise to distinguish between what one practitioner has called the "the lofty and the nitty gritty" — between "helping young people realize their true potential" and "helping young people delay premature sexual activity by six months."

Putting It All Together: Developing a Program Model

It can be useful to conceptualize a program linearly:

Needs and Resources → *Goals* → *Process* → *Outcomes* → *Impacts*

However, program planning is often less orderly. Sometimes, as in the examples given above, a community may have an obvious need — an overwhelming number of single-parent families — or an obvious lack — no sex eduction in the schools — that will determine the shape of the program. Or the target population may be evident — if, for instance, a school's dropout or pregnancy rate is high among certain populations. Funding and a sense of what will be acceptable in a certain political situation may also determine program content. Further, whatever strategies and activities the program chooses initially, they may well change "in the hotbed of practice":

> A flexible attitude is a must. Whatever you start out with, you let your program grow with the kids. — UMSAPPP project director

Still, developing a model, like the one given on the next page, can be a useful way to assess how realistic expectations are: Can the planned process be expected to bring about the desired outcomes and impacts? Are staff, resources, and program activities realistic and sufficient?

PROCESS	OUTCOMES	IMPACTS
Weekly family life course	Increased knowledge, especially of risk of unprotected intercourse	Decreased pregnancy rates
Six-week abstinence component	Increased ability to resist peer pressure and to communicate with peers	Delay of sexual initiation
After-school remediation program for high-risk students	Improved grade point average and decreased class cutting	Decreased school leaving and increased graduation rates
Community service component	Increased awareness of world of work	Enrollment in postsecondary education, obtaining a job
Provision of contraception or referral to community agency	Increased use of contraception	Decreased pregnancy and STD rates

Adapted from a chart in Susan Philliber, *Evaluating Your Pregnancy Prevention Program: How to Get Started* (Washington, DC: Adolescent Pregnancy Prevention Clearinghouse, Children's Defense Fund, 1989).

Overcoming Obstacles

Numerous barriers may stand in the way of initiating and sustaining pregnancy prevention activities in the middle grades. A number of these are outlined below, along with strategies for dealing with them.

Getting People to Admit That the Problem Exists

Many adults — educators and parents alike — feel very uncomfortable dealing with adolescent sexuality and specifically dealing with the fact that many teens are sexually active. The planning stage's needs assessment documenting rates of sexual activity, contraceptive use and pregnancy among local teens can help overcome this barrier. In addition, being armed with the facts about national pregnancy and sexual activity rates, the negative long-term consequences of too early pregnancy and parenting, and of the general support for family life education and school-based clinics can also help. A number of organizations from which such information is available are listed in the resources section of this chapter, and many relevant statistics are summarized in the appendix.

Keeping Pregnancy Prevention on the Front Burner

In many urban schools and districts, administrators are aware of the problem, but are faced with so many other problems — drugs, violence, family violence — that pregnancy prevention is a low priority.

> In my school, the climate has changed as far as seeing teen pregnancy as pressing. You don't see the pregnant girls because they tend to drop out. You can't see the curtailed opportunities and the diminished achievement of the children born to teen mothers. But the drugs and the violence — those are visible. There have been five murders in our school in the past two years. The prevailing attitude to pregnant girls is, "These girls will live." — UMSAPPP project director

To counter this barrier, it is vital to insist on the interrelatedness of risk behaviors — that early initiation of any one behavior appears to predict the others, with school failure often the precipitating event. As one UMSAPPP project director expressed it: "You have to fight the *triage* that takes place in many urban schools. When I talk about too-early pregnancy, I really emphasize that it's not an isolated thing. It's part of a much bigger picture." Emphazing the common elements of much prevention programming (see chapter 2) can also help counter this barrier.

Bureaucratic Problems

Another type of barrier can come in the form of bureaucratic red tape that can affect such factors as the hiring of staff, the scheduling of classes, or the use of nonschool personnel for presentations. One UMSAPPP project was stymied for months because of a union hiring freeze and challenges by the teachers' union that prohibited the hiring of any nonunion personnel. Another school was unable to schedule an after-school program because the school buses could not be scheduled to take students home late. The UMSAPPP experience suggests that hiring someone from the outside as program director or coordinator to work with all members of the collaboration can help deal with such bureaucratic barriers.

What qualities should such a person have? Ideally, he or she would have a good working knowledge of schools, strong ties to the community, dedication to young people and a commitment to youth empowerment, knowledge of teen pregnancy and pregnancy prevention issues, experience managing programs, flexibility, patience, and a risk-taking attitude. Practitioners emphasize this last quality as essential (although, paradoxically, practitioners are striving to curtail risk-taking in young teens!):

> You must have a risk-taking mentality. There are systems that need to be broken into. An outside person tends to take more risks, question policies, confront obstacles and in general offer an element of surprise. — UMSAPPP project director

Hiring an outside coordinator can also help with another barrier toward implementing effective pregnancy prevention activities — dilution of content. The focus on pregnancy prevention can be lost for a number of reasons: pregnancy prevention may be added or integrated into an existing program by a teacher or group of teachers with many other responsibilities; fear of controversy can also be a factor. This dilution seems less likely in situations where the program facilitator is hired from outside the school system, expressly for the purposes of initiating pregnancy prevention activities:

> I can take more risks because I'm not responsible to the principal, and he doesn't feel that he has to regulate my activities as much as if I were a regular staff member. — UMSAPPP project director

> My program is located in a building next to the school, and I am paid as a consultant. In some ways this creates a healthy distance between the school and our program. I have a good relationship with the school, but I am able to bring in Planned Parenthood to do presentations and make referrals in a way that I couldn't if I worked within the school. In some ways, our program is a safety valve providing vital services that the school is not able to provide. — UMSAPPP project director

Identifying and gaining the support of "key people with clout" — individuals within the system who have power — can also facilitate dealing with bureaucratic barriers. These people can help the program bypass bureaucratic roadblocks and gain access to key individuals in the schools, the district office, and the community. One UMSAPPP project director advised: "You have to know when to play by the rules and when not to. There are people on the inside who can pave the way." An important aspect of this process is becoming known so that agencies and district personal can "put a face to a program." In the words of an UMSAPPP director: "You have to build up personal loyalties. You develop personal relationships with people in the district office and in community agencies so that when things get rough, they're there for you."

Teacher Overload and Reluctance

Another barrier to successful implementation of pregnancy prevention activities can be teacher overload. Many teachers are overwhelmed by the number of problems they must address, in addition to teaching; this is especially true in urban schools. Teachers also are often reluctant to take on pregnancy prevention because of fears of adverse reaction from parents and administration. They speak of restraints — both formal and informal on what they can teach. And many feel a certain discomfort dealing with certain issues. (Chapter 17 presents suggestions for dealing with these barriers.)

Resources

Alan Guttmacher Institute, 111 Fifth Avenue, New York, NY 10003.

> A research, policy analysis, and public education organization in the reproductive health field. Primary source for national statistics on adolescent pregnancy. Publishes *Family Planning Perspectives* six times a year.

Brindis, Claire D. *Adolescent Prevention Pregnancy: A Guidebook for Communities*. Palo Alto, CA: Standford University, Health Promotion Resource Center, Stanford Center for Research in Disease Prevention, 1991.

> Covers every aspect of implementing a collaborative, communitywide adolescent pregnancy prevention initiative: putting together a broad-based coalition; making coalitions work; facing controversy; conducting a communitywide needs assessment; developing an implementation plan; dealing with the media.

Center for Population Options, 1025 Vermont Avenue. NW, Washington, DC 20005.

> A national organization with the primary objectives of reducing the incidence of unin-

tended teenage pregnancy and preventing sexually transmitted diseases. Provides training in the development and implementation of family life education programs. Produces publications on life planning and sexuality education. Also operates Support Center for School-Based Health Clinics.

Child Trends, 2100 M Street NW, Washington, DC 20037.

A research organization focusing in particular on the effects of government policies and social change on the lives of U.S. children and their families. Publishes *Facts at a Glance*, an annual fact sheet with statistics on teen births, pregnancies, abortions.

Children's Aid Society, National Training Center for Adolescent Sexuality and Family Life Education, 350 East 88 Street, New York, NY 10128.

Runs the Bernice and Milton Stern National Training Center for Adolescent Sexuality and Family Life Education, a national training center offering intensive training to social services and youth-serving institutions interested in establishing programs offering young people and their families a comprehensive and holistic approach to pregnancy prevention.

Children's Defense Fund, 122 C Street NW, Washington, DC 20005.

A national child advocacy and research organization; operates Adolescent Pregnancy Prevention Clearinghouse; monitors government activities; has information on federal and state policies and a wide array of publications on teen pregnancy and adolescent pregnancy prevention.

Education, Training, Research (ETR) Associates, Box 1830, Santa Cruz, CA 95061-1830.

A private, family life and health education organization offering training and technical assistance in basic health education and evaluation of educational approaches. Publishes *Family Life Educator*. Network Publications, a division of ETR Associates, is the country's largest publisher of family life and health education resources and materials.

Lindsay, Jeanne and Sharon Rodine. *Teen Pregnancy Challenge. Book 1, Strategies for Change: Developing Adolescent Prgnancy Prevention Programs*. Buena Park, CA: Morning Glory Press, 1989.

Contains information on initiating pregnancy prevention programs: how to document the need, build community support, determine program setting, evaluate effectiveness, advocate with policymakers, and conduct long-range planning.

National Organization for Adolescent Pregnancy and Parenting, Inc.(NOAPP), 4421-A East West Highway, Bethesda, MA 20814.

A national membership organization dedicated to preventing adolescent pregnancy and problems related to adolescent sexuality, pregnancy and parenting. It sponsors an annual conference and other training for professionals concerned with adolescent pregnancy and parenting, and publishes a newsletter, *NOAPP Newtwork*.

Phillibber, Susan. *Evaluating Your Adolescent Pregnancy Program: How to Get Started.*

Washington, DC: Adolescent Pregnancy Prevention Clearinghouse, Children's Defense Fund, 1989.

Provides suggestions about planning an "evaluable" program: how to develop a model and determine process, impact, and outcome objectives.

Search Institute. *Profile of Student Life.* Minneapolis: Seach Institute, 1989-90.

Consists of three surveys — on substance abuse, attitudes and behaviors, and sexual activity. Available for use by school districts and communities.

Sex Information and Education Council of the United States (SIECUS), 130 West 42 Street, New York, NY 10036.

Operates extensive library on human sexuality and sex education; produces bibliographies on specific subjects and a number of publications, including a monthly newsletter.

Notes

1. Jeanne Lindsay and Sharon Rodine. *Teen Pregnancy Challenge. Book 1, Strategies for Change: Developing Adolescent Pregnancy and Prevention Programs* (Buena Park, CA: Morning Glory Press, 1989).
2. Susan Phillber, *Evaluating Your Pregnancy Prevention Program: How to Get Started* (Washington, DC: Adolescent Pregnancy Prevention Clearinghouse, Children's Defense Fund, 1989).

Chapter Fifteen

Handling Controversy

> If you determine what the community will readily accept and what problems may come up before you begin, you can avoid a lot of trouble down the road. — Community-based organization director

Initiating pregnancy prevention activities in the middle grades can entail a certain amount of controversy. This controversy usually focuses on the belief that pregnancy prevention or sex education promotes sexual activity, the fear that sex education usurps the role of families, and the issue of contraception. The AIDS crisis has changed the intensity of the controversy to some degree in recent years. That is, support for AIDS education in the schools and for education about condom use has been growing. Nevertheless, controversy does arise, robbing program staff of the kinds of supports they need and sapping valuable time and energy. This controversy often reflects the opinion of relatively few vocal individuals and groups. As one UMSAPPP project director said: "You have to understand that there is usually a vocal 10 percent minority that are opposed. In our case, the opposition boiled down to two parents and the cardinal."

It is vital that those involved in planning and implementing pregnancy prevention activities in the middle grades be prepared to handle the controversy that may arise. The strategies described below are based on the experiences of the UMSAPPP projects and other pregnancy prevention programs. They entail assessing the community, building community support, and dealing with the media.

Assessing the Community

Assessing a community's readiness to accept a pregnancy prevention program in the middle grades, and what type of program, is an essential task before planning and implementing a program. This assessment involves talking to parent groups, educators, staff in community-based agencies, and clergy. Some educational activities may be necessary — a forum or speak-out on the problem of too-early pregnancy in the community, and on what steps other communities and school districts are taking to combat this problem. Assessing the community also entails determining who the opposition is — which groups and organizations are most likely to be opposed to the envisioned program. In dealing with these groups, several strategies have proven successful:

Find Areas of Agreement

Even groups with very different goals and ideas about how to achieve these goals can

nearly always find some areas of agreement. Most people, for example, are concerned about the welfare of children and families and about the negative consequences of too-early parenthood. Most people are also concerned about public expenditures; the early planning stage is a good time to promote the long-run cost effectiveness of pregnancy prevention. An important part of finding areas of agreement is being a good listener:

> It is crucial not to dismiss the concerns of the opposition and to avoid rhetoric and jargon in discussing the issues. You find as many points of agreement as you can — and then just agree to disagree. — UMSAPPP project director

Find a Member of the Opposition Who Agrees with You

It is almost always possible to find community members who agree with a specific strategy even though they may seem to be in the opposition's camp. For example, a clergy member who supports a particular aspect of a program even though members of his or her congregation do not can help defuse controversy; parents who want pregnancy prevention activities in the school can testify at public meetings or can speak to the press.

Relevant Statistics Relating to the General Support of Sex Education/Family Life Education in the Schools

According to the results of a 1986 survey, 77 percent of Americans believe that sex education courses for 12-year-olds should include information about birth control, and two thirds believe that they should cover abortion and homosexuality.[1]

A study of sex education teachers revealed that almost all teachers believe public schools should teach a wide range of subjects relating to the prevention of pregnancy, AIDS, and other sexually transmitted diseases. Most believe that students should learn about these topics *by grades 7-8 at the latest.* And, while 97 percent said that sex education classes should include information on where students can go to obtain birth control, only 48 percent are in schools where classes cover this.[2]

The National School Boards Association reported that 80 percent of the nation's schools offer AIDS education: 85 percent offer it in the seventh grade; 94 percent allow students to be excused from these classes — but *fewer than 1 percent of parents exercise this option.*[3]

Overall, *98 percent* of parents say they need help in discussing sexuality with their children.[4]

Various studies have proven that traditional family life/sex education has little impact on rates of sexual activity: it does not influence frequency of coitus, and it does not encourage teens either to initiate or postpone becoming sexually active.[5]

In fact, the majority of sexually active young teens have not had a sex education course before they become sexually active. Among those who first have sex at age 15, only 48 percent of girls and 26 percent of boys have had a sex education course. Even among teens who first have sex at 18, the proportions who have had a sex education course are not high: 61 percent of girls and 52 percent of boys.[6]

Make the Facts Work for You

Often those opposed to pregnancy prevention are laboring under certain misconceptions. It is vital to be armed with the documented evidence that sex education does not promote sexual activity and that many surveys have shown an overwhelming support for sex education, including pregnancy prevention, among parents and teachers in the middle grades. Knowing about other programs across the country will also be useful in heading off some criticism. Stressing the comprehensive nature of a program and all the benefits it will provide for young people besides providing information about sexuality will also help. In addition, the information provided in chapter 1 and summarized in the appendix should prove useful: the increased rates of sexual activity among young teens; the long-term negative consequences of too-early pregnancy and parenthood; the connection between pregnancy and dropping out of school, and the importance of the middle grades in determining the educational future of students.

Planners should always present sex education and pregnancy prevention in the schools as helping — not supplanting — families. It may be useful to engage the opposition in discussion of the kinds of strains that families are frequently under, given the changes in family structure and the increased number of women with children in the labor market.

Building Community Support

It is vital to build broad support among agencies, parents, churches, teachers, and district-level personnel for pregnancy prevention programs in the middle grades. Much of this support will evolve during the collaborative process. It is important also not to limit contact to those agencies that have the same definition of the problem — that is, ones specifically concerned with pregnancy prevention or even health. Educators or community-based agency staff concerned about dropout prevention or job counselors concerned about the poor job skills among young people can also be allies.

The more comprehensive a program and the more varied the approaches to preventing too-early pregnancy, the greater the support of such agencies will be. "It is essential," advises one UMSAPPP project coordinator, "to interact among agencies so that your program has allies. The more groups and people you talk to right from the beginning, the more support you will have when the going gets rough." Involving parents is an important aspect of building community support for a program. Doing so can be a great defense against controversy and can help defuse the myth that family life education supplants families. As one middle school principal testified: "Parents can be your best ally against controversy." (Chapter 4 discusses strategies for involving parents.)

Dealing with the Media

Successful implementation of a pregnancy prevention program requires skillful handling of the media. Some advice, based on the UMSAPPP experience, on how to make the media work for — and not against -- a program follows.

Put the Program in Place Quietly and Document Everything.

Depending on the political climate, it may be wise to implement the program in as undramatic a way as possible: "In the beginning," said one UMSAPPP project director, "we kept our program low-keyed but not hidden." It is essential to document everything — number of students, types of services, and promising results — for use when the need arises. Almost everyone who has encountered controversy in pregnancy prevention agrees that "you can't keep your program secret forever," and that in the long run, it is best "to meet the controversy head on":

> You can waste a lot of time just trying to avoid controversy. At some point, you have to confront the opposition; but in order to do this, you have to be prepared. — UMSAPPP staff member

To do this, program planners must have a well-defined position and be knowledgeable about local and national statistics on teen pregnancy and sexual activity; about how communities and school districts are responding to the issues across the country: and perhaps most important, about what their program is doing.

> Remember that the press can be totally irresponsible. They will focus on the fact that a program is advising students about contraception and not mention all the other things it does. Don't be caught by surprise. You have to control not only what the press says about your program but when. — UMSAPPP project director

Don't Face the Media Alone

Another strategy for dealing with the press is not to do it alone: face the press with representatives from collaborating agencies, the schools, and the district office.

> Never face the press alone. Look for someone with some political savvy who is positioned to help make things smooth. And don't wait until there's trouble. — UMSAPPP project director

> We encountered the most controversy when we had completed our needs assessment. The media focused immediately on sexual activity and drug use in our school. We had a news conference at which the superintendent, the school board president, and I talked about risk-taking behavior among adolescents and some nationwide responses. Since that time, there has been nothing "newsworthy" because of our success. — UMSAPPP project director

If controversy does arise, it is essential to remain positive and not to be put on the defensive by the press or by misrepresentations about a program:

> We bend over backwards to justify ourselves to small groups of people when our young people are becoming casualties before us. We have to put the opposition on the defensive. We've been apologetic too long. Why don't they want our children to have this great program? — Pregnancy prevention program director

Plan a Process for Dealing with the Media

Another tactic for dealing with the media is to plan a process for doing so. One such plan is as follows:

- Designate one person as the facilitator or contact person with the media and as the major source of information about the program.
- Identify potential editorial support in the media and maintain contact with it.
- Identify television and radio programs involved in public affairs programs and maintain contact.
- Develop a list of spokespeople for the program — educators, parents, clergy, and community-based agency staff. Make sure they all have the same information about the program: its history, aims, activities and results. Make this description free of jargon.
- Conduct a forum on the program's issues for news reporters, editors, and public affairs program producers.
- Anticipate events likely to attract media attention, and make sure all involved are briefed.
- Document community support for the program and support for similar kinds of programs nationwide.
- Celebrate program successes publicly. Invite the press to events that show what the program is doing and what effect it is having on the young people.[7]

Practitioners agree that controversy, properly handled, can provide a great opportunity to build support for a program. Controversy can elicit support from unexpected quarters:

> You'd be surprised how much support you'll get after the controversy erupts. People are keeping a low profile, but once the battle starts, they rally to your cause. — UMSAPPP project director

Resources

Lindsay, Jeanne, and Sharon Rodine. *Teen Pregnancy Challenge. Book 1. Strategies for Change: Developing Adolescent Pregnancy and Prevention Programs.* Buena Park, CA: Morning Glory Press, 1989.

Contains a chapter on marketing a program and dealing with the media.

Notes

1. Asta M. Kenney et al. "Sex Education and AIDS Education in the Schools: What States and Large School Districts Are Doing," *Family Planning Perspectives* (Vol. 21, No. 2, Mar./Apr. 1989).

2. Jacqueline Darroch Forrest and Jane Silverman, "What Public School Teachers Teach About Preventing Pregnancy, AIDS and Sexually Transmitted Diseases," *Family Planning Perspectives* (Vol. 21, No. 2, Mar./Apr. 1989).

3. National School Boards Association, "H.I.V. Prevention Education in the Schools," *Education Week* (Feb. 28, 1990).

4. Alan Guttmacher Institute, Teenage Pregnancy: *The Problem That Hasn't Gone Away.* New York: (Alan Guttmacher Institute, 1981).

5. Douglas Kirby, *Sexuality Education: An Evaluation of Programs and Their Effects,* Vol. 1 (Atlanta, GA Bureau of Health Education, Centers for Disease Control, 1984); William Marsiglio and Frank L. Mott, "The Impact of Sex Education on Sexual Activity, Contraceptive Use and Premarital Pregnancy Among American Teenagers," *Family Planning Perspectives* (Vol. 18, No. 4, July/Aug. 1986); and Deborah Anne Dawson, "The Effects of Sex Education on Adolescent Behavior," *Family Planning Perspectives* (Vol. 18, No. 4, July/Aug. 1986).

6. Marsiglio and Mott (see note 5).

7. Adapted from Howard Klink, "Managing the Media: A Fifteen Step Plan," *Clinic News* (Winter 1989). Reprinted with permission from the Center for Population Options.

Chapter Sixteen

Promoting Effective Collaborations

> You look for organizations that have a reputation for strong programs for youth. But there's always the problem that you'll stick to the ones you know and feel comfortable about. There may be other groups out there, there may be individuals in those agencies who are dying to get into the schools. You have to get the word out. You have to tap into some of those resources you may not know about. — UMSAPPP project director

To be effective, collaborations between community-based agencies and the schools must not be sporadic encounters, one-shot deals with agency staff providing services for one semester or teaching a few classes. Successful collaborations must evolve over time and must provide each partner with something it could not otherwise get — namely, the access and resources that are the major benefits of collaborations. The UMSAPPP experience shows that a number of issues typically arise in forming collaborations. These are summarized below.

Structure: Who is in the collaboration? How large is it? Will the collaboration work to accomplish only specific goals or is it an ongoing relationship? Who determines who the members are, and how? To what extent are collaborators committed and involved? Do members provide direct services to students, or do they participate in other ways?

Power: Which partner has the authority to make programmatic and funding decisions? Does a committee make or review decisions, or is one agency or person responsible? Who hires staff? To whom do staff report? On what scale are staff salaries calculated — that of the school system or that of a collaborating agency?

Goals: What are the goals of the collaboration? Do all partners share these goals? Do some collaborators have different or additional goals — to prevent dropout, to improve access to health services, to increase cultural pride, to improve school achievement? Do any of these goals conflict?

Funding: What is the source of funding for collaborative activities? Do collaborators' operating budgets cover some or all activities? What in-kind services do members contribute? For what time period is funding secured?

Choosing Collaborating Agencies

No foolproof way exists for selecting collaborating agencies. Organizations with a strong history of engaging youth in their programming, those concerned with adolescent pregnancy prevention, and those with a history of working with schools are good places to

start. Sometimes agencies that should be interested in collaborating, given their mandate, are unresponsive, while others, which might not seem ideal, are eager to serve students: "Once school districts express a willingness to collaborate," said one UMSAPPP project director, "you'd be surprised how many agencies will be there." In particular, collaborations between two large bureaucracies — the schools and the department of health, for example — may well prove unwieldy, given the amount of red tape that may be encountered. After a year of delays and problems, one UMSAPPP project director said, "Getting the schools to move is difficult enough. Getting the schools and the county health department to move at the same time is something else again!"

Building a network of contacts is an important aspect of forming collaborations, and an especially important one in terms of working against the problems of staff changes. Staff changes in agencies can destroy previous efforts to set up systems:

> You can't just have one contact per agency; you have to build networks of support. If someone is moving on, make sure he or she introduces you to his or her successor and puts in a plug for you. — UMSAPPP project director

The UMSAPPP experience demonstrates that involving too many collaborators will increase dramatically the time and energy spent on planning and implementing services, while engaging too few will leave the collaboration vulnerable to staff changes within agencies and the school, and to changing budget priorities. When the Atlanta public schools held their planning conference on adolescent pregnancy prevention, 105 agencies sent representatives. These groups provided important services that school staff needed to know about, but only about 10 percent of them could undertake activities. Milwaukee began its planning with four agencies that had experience with the schools. Kansas City began its collaboration with a single umbrella agency for youth services, which could coordinate the resources of others. In some collaborations between schools and community-based agencies, it may be wise to link one school and one agency together on the basis of geography or particular needs. This was the approach in Boston, where the collaboration had many members, to ensure that each school had one major collaborating agency to go to first for help.

The Big Word is Share

The experiences of the UMSAPPP projects suggest a number of ways to develop good collaborations. Perhaps most important, practitioners experienced in working collaboratively agree that sharing power, resources, and credit is essential if collaborations are to work effectively.

> The big word is share — but you have to share more than information. You have to share power; you have to share resources; and, most of all you have to share the credit. — UMSAPPP project director

Sharing power can pose a real problem among collaborating agencies, especially if some partners are larger, older, or more established in the community than others. Collaborations will break down if one member acts without consulting other partners: if for example, the

school district decides that the role of other members of the collaboration is purely advisory. Turf issues may also arise — specifically, regarding the location of meetings and the question of who sets the agenda for meetings. It may be important to meet in a neutral space, especially at first. In some cases, a brokering agency — a neutral party — may be involved during the initial stages to facilitate all aspects of the collaboration.

As with handling controversy, hiring an outside consultant can sometimes help the collaborative process. A consultant can facilitate communication and keep the agenda focused clearly on project goals. This person can be hired jointly by the school district and a consortium of agencies and can operate without the distractions and constraints experienced by school and community-based agency staff:

> I was hired as an outside consultant. Things had stagnated before I was brought on. I didn't have to speak a public school line. I wasn't hired by the unions, my upward mobility in the system wasn't at risk, I could take more risks. — UMSAPPP project director

Sharing information is an important aspect of effective collaborations. Members should hold regular meetings and should devise some mechanism to keep those who are unable to attend informed. This sharing of information can be one of the functions of a neutral group. Providing a directory of services and a newsletter and conducting an annual conference are also ways to share information. Sharing funds and other resources will make the advantages of collaborations obvious to all partners. For example, a school district may hire staff from community-based agencies to do staff development or to make presentations at school assemblies or in individual classes.

It is important that all members of the collaboration receive credit for activities and outcomes: "It's no good," warned one community-based agency director, "if one of the collaborators has a hidden agenda and wants to use the achievements of the collaboration to promote its own image." When programs, activities, or events take place or receive media coverage, all members of the collaboration must receive credit. In Boston, the UMSAPPP project organized a networking appreciation day to highlight the efforts of collaboration members. Celebrating collaboration efforts with events — health fairs, teen forums, dramatic performances — can be a great way of bringing together all collaborative partners, focusing their attention on the most important aspect of the collaboration — the young people:

> Sometimes the kids get lost. We often used meetings of the collaboration to highlight student work: they did performances, displayed their art, made presentations on relevant issues. Once we even involved young people in mediating a dispute. Whatever — we just wanted to keep the kids right in the center. — UMSAPPP project director

> There are ultimately no rules. Collaborations are dynamic. You have to keep working at them, and when the going gets rough, you remind yourself that you're in it for the kids. — Community-based agency director

Resources

Brindis, Claire. *Adolescent Prevention Pregnancy: A Guidebook for Communities.* Palo Alto, CA: Health Promotion Resource Center, Stanford Center for Research in Disease Prevention, 1991.

Contains information on every aspect of establishing collaborative pregnancy prevention program and on working collaboratively.

Center for Human Resources, Heller Graduate School. *A Guide to Working Partnerships.* Waltham, MA: Brandeis University, 1988.

Covers the major issues of building and maintaining effective collaborations.

Lindsay, Jeanne and Sharon Rodine. *Teen Pregnancy Challenge. Book 2, Programs for Kids: From Primary Prevention to Parenting Support.* Buena Park, CA: Morning Glory Press, 1989.

Contains a chapter on building community coalitions.

Nash, Margaret and Margaret Dunkle. *Promoting Collaboration, Promoting Success.* Washington, DC: Equality Center, 1988.

Provides many suggestions for promoting effective collaborations.

Chapter Seventeen

Staff Development

> In-service helped teachers have a greater understanding of adolescent development and of risk-taking behaviors and encouraged them to look at the whole child before writing them off academically. — UMSAPPP project director

> Teachers felt empowered from their increased competency and comfort level gained from the in-service in teaching family life education. — Family life education teacher

Staff development — both initial and ongoing — is an essential part of pregnancy prevention activities. It has many purposes:

- To increase a sense of ownership and commitment to the program on the part of school or district staff
- To increase knowledge — about the scope of the teen pregnancy problem, both nationally and locally; adolescent development and sexuality; particular methods of birth control; and community resources
- To enhance comfort level with sensitive issues like birth control, abortion, and sexual preference
- To increase staff awareness and stimulate sharing of effective teaching strategies, especially for enhancing youth empowerment
- To dispel common myths about family life education — that it encourages sexual activity, that it has no values, that it usurps the role of the family
- To increase awareness of certain biases — of race, culture, and class — and to increase awareness of gender equity issues
- To provide supports for teachers and counselors and opportunities for reflection, sharing, and networking

In some situations, staff development may be offered for credit through collaborating universities. This was the case in the UMSAPPP Norfolk project, where two institutions of higher learning trained teachers in sexuality and family life education.

Fostering Ownership Among School or District Staff

New initiatives are often thrust upon schools. Practitioners advise that teachers and other staff must be involved in pregnancy prevention activities from the planning stages on. School staff must understand that pregnancy prevention activities are not just another add-on program — an increased responsibility to burden them. Effective staff development

must demonstrate to teachers that integrating pregnancy prevention activities in a comprehensive and collaborative way will give them "allies in the fight" and, specifically, that staff from collaborating agencies can relieve teachers by providing services and making presentations that teachers prefer not to make. Initially, focus groups or interviews can elicit staff's concerns about how the school or the district should address too-early sexual activity and parenting and how they would like to be involved.

Overcoming Teacher Reluctance

Many teachers may be reluctant to participate in the initiation of pregnancy prevention activities for a number of reasons. They may feel uncomfortable with the issue of teen sexual activity and may feel it violates their personal values:

> The greatest barrier we faced in undertaking pregnancy prevention activities was persuading adults to set aside their personal perceptions and values surrounding human sexuality and pregnancy prevention in order to focus on the needs of middle school students. — UMSAPPP project director

Programs that educate staff on the extent of the problem in their school, district, or city can help in this situation:

> Staff were truly shocked by the extent of the teen pregnancy problem in our area. Even people who were very reluctant ended up saying we had to do something for the young people. In-service created an urgent sense that we all had to work together for the shared goal of preventing pregnancy and promoting positive outcomes for our young people. — Family life education teacher

Some staff may feel uncomfortable about assuming a role that has typically belonged to the family. Having parents involved in planning activities or holding a school or community meeting to discuss the issues can help in this respect.

For many staff, however, the biggest problem is overload. Most teachers are already overwhelmed by the number of problems to which they must respond. Having practitioners speak of the many rewards of being involved in pregnancy prevention activities in the middle grades can be an effective way of overcoming teacher reluctance. Practitioners have testified movingly about these rewards.

Pregnancy prevention activities can empower teachers to talk about sensitive issues — things they may already be dealing with but not feeling supported for:

> The program enabled me to deal with subjects that were otherwise off limits. — Family life education teacher

> The program legitimated my efforts to help students make responsible choices. In the past I felt I had to do this on the side, and I was always worried about what would happen if word got out that I was talking too much about pregnancy prevention. — Middle school counselor

> Just seeing the district assume "ownership" of the problem has been a reward in itself.

> I had been trying to convince district leadership of the extent of the problem for years. — UMSAPPP project director

Involvement in pregnancy prevention efforts can provide opportunities for professional growth:

> Being in on something new from the beginning and helping it grow and develop has been very exciting. Working with people who genuinely care about young people and trying to figure out with them what teens need has been very rewarding professionally. — UMSAPPP staff member

> I felt I was part of a national movement, and I became very energized by a sense of the importance of what we were doing. — Family life education teacher

Pregnancy prevention activities can be rewarding in and of themselves:

> Helping young people make informed choices has been the greatest reward, just being there for them in ways their families couldn't be. — Middle school counselor

> When I taught family life in high school, I knew it was already too late. Now I feel I can have an impact on students while there's still time. — Family life education teacher

> Most of all, seeing the students grow, open up, and start to take control of their own lives was the greatest reward. That's what kept me at it day after day. — UMSAPPP project director

Effective Staff Development Is Collegial

The more collegial staff development is, the more effective it will be. Thus, teachers must be involved in planning and undertaking staff development that empowers them by giving them a sense of control over and excitement about the work. Teachers also need ongoing supports and opportunities to share their work with others in the field. Creating the sense that a program is part of a movement by participating in citywide conferences, linking it to successful projects statewide and joining in statewide advocacy efforts can help provide such opportunities. Above all, teachers must feel respected as professionals. The opportunities for professional and personal growth that effective staff development provides will reflect this respect.

Building Action Plans

Ideally, in-service can also play a vital role in creating a "climate of ownership" in a particular school by making pregnancy prevention the responsibility of the whole school and not just of the health science teacher. When this happens, pregnancy prevention activities can be a catalyst for change in a school. On a modest scale, this kind of change occurred in the Milwaukee UMSAPPP project, where extensive staff development led to the development of "building action plans" — activities that staff from each school developed to combat the problem of too-early pregnancy.

Milwaukee has an extensive human growth and development curriculum in the middle grades and a history of schools, community groups and agencies working collabora-

tively to address student problems. It also has a considerable teen pregnancy problem: its teen birth ratio (the proportion of births that are to women under 20) is considerably higher than the national average.[1] Thus, the UMSAPPP project there took on the major goal of organizing middle grades teachers, administrators, and counselors to work in a concerted fashion on preventing teen pregnancy. This work entailed extensive in-service training in which staff from collaborating agencies trained teachers and staff from participating middle schools. The in-service sessions "removed pregnancy prevention from the academic arena of health and presented it as an all-school affair." Teams from each school developed building action plans that included schoolwide events such as health fairs, parenting sessions, staff development sessions, and classroom instruction. Each middle school was teamed up with a collaborating agency to help with the implementation of these building action plans. This staff development and the pregnancy prevention activities that followed were invaluable for the staff and improved their handling of pregnancy prevention:

> In many of our middle schools . . . staff have come to understand and act upon the notion that pregnancy prevention belongs to all of us responsible adults who spend large portions of our lives teaching and influencing adolescents. They are acting on their beliefs that pregnancy prevention is not learned just in science and health classes; it's related to how youngsters feel about themselves, how they view the future, how they seize the options they have open to them, and how adults respect and relate to them. — UMSAPPP project director

Resources

Loucks-Horsley, Susan et al. *Continuing to Learn: A Guidebook for Teacher Development.* Andover, MA: Regional Laboratory for Educational Improvement on the Northeast and Islands, 1987.

> An overview of effective teacher development programs and techniques.

Wagman, Ellen and Lynne Cooper. *Family Life Education Teacher Training Manual.* Santa Cruz, CA: Network Publications, 1981.

> Provides suggestions for staff development, specifically regarding family life education issues.

Note

1. Adolescent Pregnancy Prevention Clearinghouse, *Teenage Pregnancy: An Advocate's Guide to the Numbers* (Washington, DC: Children's Defense Fund, 1988).

Chapter Eighteen

Funding

Securing funding for pregnancy prevention programming is one of the major initial tasks of the collaboration. In fact, one of the great advantages of collaborations is that finding funding becomes the responsibility of all partners and, ideally, enhances ownership of the program among collaborative members. Securing funding entails three important steps: identifying funding sources, writing a funding proposal, and developing a working budget.

Identifying Funding Sources

The following are standard sources of funding for pregnancy prevention initiatives:

- Local boards of education
- Local community development programs and initiatives
- Government grants
- Local charitable organizations (for example, the United Way)
- Private foundations
- Local health departments
- Civic organizations (for example, the Chamber of Commerce)
- Churches or church groups
- Businesses and corporations
- Individuals

Some funding sources prefer to provide start-up funding (seed money) or even planning money, while others prefer to support a program that is already operating and has a proven track record. Also, the goals and target population of a program affect the kinds of funding available. Thus, before approaching a potential funding source, a program must outline its goals, target population, and activities, as well as sketch a working budget.

Most federal money is categorical — that is, geared to respond to a particular problem. For example, funding is available from the Centers for Disease Control (CDC) to provide training in AIDS education, and funds are available for abstinence education from the federal Office of Adolescent Pregnancy and Parenting. While the categorical nature of much funding poses a barrier to providing general support for a program, practitioners have often found ways around this. For example, the growing AIDS crisis has given an impetus to linking AIDS and other risk prevention education. In Boston, the efforts of the

UMSAPPP project were linked to AIDS education efforts with funds from the CDC. In Wisconsin, Prevention Connections is a comprehensive health program initiated with CDC funds for AIDS education. As one UMSAPPP project director expressed it: "You have to think comprehensively and fund categorically. You have to look for ways of funding creatively, of forging links with other, related services."

Another example of such creative funding would be including pregnancy prevention activities in programs that dropout prevention funds support. This could certainly be justified given the connection between pregnant and parenting status and school leaving. Pregnant and parenting females make up half of all female dropouts and one-quarter of the dropout population (see chapter 1), yet little dropout prevention money has traditionally gone to services for pregnant and parenting students or to pregnancy prevention activities. Similarly, the costs of STEP (see chapter 13) are partially covered in many sites by JTPA funds. Programs, such as school-based clinics, are often eligible for Early Periodic Screening, Diagnosis, and Treatment (EPSDT), Maternal and Infant Child Health, and Medicaid funds, and those offering job-related education may be eligible for grants from the Department of Labor.

Local foundations are another potential source of support. Many have particular mandates or work with particular populations. In a given community, programs may tap other coalitions or groups — church groups, charitable organizations — for support for an activity. And, in light of recent attention to the "skills gap," programs may appeal to business, industry, and civic organizations for certain types of funds — for example, to provide job readiness skills or career awareness education.

In some communities, programs may ask wealthy individuals or particular churches to provide partial funding for a program. In doing so, it is usually most effective to be very concrete and specific: programs can ask an individual or church to help pay the rent or provide recreational supplies for an after-school program or money to take students to cultural events; or they may ask a business or corporation to help purchase equipment for a job training component or to provide lunch at a program-sponsored event.

Special events can be another source of income for a program. While in themselves they may not raise much money, such events as fashion shows and cultural performances can serve other purposes. They highlight the achievements of the young people, as well as provide excellent vehicles for involving them in planning activities and developing leadership skills. Special events give a program visibility and enhance a community's sense of ownership of it. They also are a way of celebrating a program, its collaborators, and its funders.

A Working Budget

A program must develop a working budget — a detailed plan of expected expenditures — before it can approach potential funders. It needs to consider and closely approximate every possible cost, from staffing, staff development, space, utilities, supplies, curricula, special events, evaluation, and outside consultants. How much funding will be necessary to initiate pregnancy prevention activities will depend, of course, on the nature and scope of these activities; how much they can dovetail with activities already underway in the school

district and community; and existing community resources that are available to the program.

In developing a working budget, it is important to distinguish between *operating expenses,* which cover the ongoing activities of a program, and *start-up expenses,* which include many one-time costs and purchases. Purchasing or developing a curriculum would be a typical start-up expense, for example, while staff salaries would be an on-going operating expense.

Another important factor in devising a working budget is in the value of in-kind contributions in the form of space, utilities, supplies, and labor. Often foundations and some government grants will require programs to match their grants with state or local in-kind monies. Planners must include these hidden costs and income to have a realistic assessment of the total cost of the program, since if arrangements change unexpectedly, the program may be forced to bear the expenses itself or find other donors.

Start-up funds must be adequate to get a program or set of activities off the ground. However, it is sometimes possible "to start small":

> You can do a lot with a little if you plan it right. Money is not the essential ingredient of a good mentor program, for example. Sometimes your success will help you get more money down the road. — Pregnancy prevention program director

The Funding Proposal

The major purposes of a funding proposal are to convince a potential funding agency that the need for a service is real and immediate, that the program design will address and alleviate the need, that the planners are capable of administering the program, and that the program will apportion and spend the money appropriately. An effective proposal contains the elements described below:

Statement of Need

The statement of need presents the results of the community needs assessment and any other evidence supporting the concept of the program. It should describe various characteristics — age, racial/ethnic group, socioeconomic status — of the target population. If the program has tentatively selected a particular site for its activities — for example, if a school-based clinic or after-school program is planned — concentrate on the specific number and needs of potential participants.

Objectives

The proposal should list the program's objectives and should describe them as concretely as possible. Objectives should be amenable to measurable outcomes. Which particular needs will each objective address?

Program Activities

This part of the proposal should describe how program activities will achieve each of

the program's objectives and should discuss briefly the basis for the usefulness of these activities.

Staffing and management

This section should describe the staffing needs and the roles and responsibilities of staff. It should include qualifications of key staff, hiring criteria, and provide a timetable for start-up operations.

Budget

Finally, the proposal should spell out how funds will be administered and should provide a budget, detailing expenditures in set categories, including in-kind contributions and additional requested funds. It should separate start-up and operating expenses, and explain items that appear particularly high or low.

Budgeting for the Future

A program's funding cycle will typically go through three phases: seed, maintenance, and expansion. The first budget will include seed monies, as well as operating expenses for the opening year. In most cases, these funds will come from sources outside the school district or community-based agency and be specially earmarked for establishing a pilot or model program. If implementation proves successful, efforts during the following year will concentrate on maintaining the program or activities at established levels. This usually means relying more heavily on in-kind contributions and on community, state, or federal monies.

Implementation is a test of the program and its components. Staffing levels may prove inadequate, expenses higher than anticipated, and demand overwhelming. However, if this is not the case, a program may wish to expand. Both of these will require rethinking and redesigning. Participant outcomes and implementation results may then be used to attract further one-time grants or to justify a larger share of appropriated funds. As long as demands for the program's services are high and community needs remain, the program has adequate reason to seek out funds for expansion.

The ultimate goal for any program or set of activities will be integration into the annual budget of the community-based agency or school district. This will require establishing an effective evaluation process that can measure program outcomes. It also requires effective lobbying within the school district and community for a permanent status. However, while every program director's dream is of going from soft to hard funding, this often does not happen. Occasionally, one position or half a position that is initially supported by outside funds may become a permanent part of a school district or community agency budget, but funds to provide other program components must still be secured. As one program director expressed it: "Fundraising is forever. I used to dread fundraising. Now I just see it as part of life!"

Involving Young People in Fundraising

Young people can be very persuasive fundraisers for programs:

> Use the kids — make it personal. Don't talk to the funders about how much the young people need the program. Have them do it. — UMSAPPP project director

> You'd be surprised how many funders give you a hard time about money. They tell you how when they were young, they had it tough, they knew how to work hard, and so on. And then you bring out the kids, and you've got them. — Business alliance director

Involving young people in fundraising efforts is especially important from an empowerment perspective.

> We're not asking funders to do the kids a favor. That's the wrong attitude. We're giving them an opportunity to fulfill their responsibility to help them develop in healthy ways, to make a successful transition to adulthood. — UMSAPPP project director

Resources

Adolescent Pregnancy Prevention Clearinghouse. *An Advocate's Guide to Fund Raising.* Washington, DC: Children's Defense Fund, 1990.

A introduction to the major issues involved in fundraising.

Brindis, Claire D. *Adolescent Pregnancy Prevention: A Guidebook for Communities.* Palo Alto, CA: Stanford University, Health Promotion Resource Center, Stanford Center in Research for Disease Prevention, 1991.

Contains information on locating sources of funding, long-term funding and writing a proposal.

Flanagan, Joan. *The Grassroots Fundraising Book: How to Raise Money in Your Community.* Chicago: IL Contemporary Books, 1982.

Contains information for local fundraising.

Lindsay, Jeanne and Sharon Rodine. *Teen Pregnancy Challenge Book 1. Strategies for Change: Developing Adolescent Pregnancy and Prevention Programs.* Buena Park, CA: Morning Glory Press, 1989.

Contains a chapter on funding.

Chapter Nineteen

Evaluation

> I was terrified of evaluation. But I had to do it. And when we discovered that we really had an impact on class cutting rates and GPA's — that made it all worthwhile. — UMSAPPP project director

Evaluation is an essential part of any program — not just because funders increasingly demand it, but because evaluation at its best should help monitor program implementation, enhance program review, and help determine the relative effectiveness of various program components. Unfortunately, demands for evaluation often intimidate and overwhelm program staff, who experience it as another obligation involving endless forms. Consequently, program staff often treat evaluation as an add-on requirement, undertaking it at the end to satisfy the funder.

The UMSAPPP grants to school districts required evaluation. Although projects received technical assistance in undertaking evaluations, many project staff approached evaluation reluctantly, as a task for which they had insufficient experience and training. Program staff concluded that, ideally, an external evaluator should undertake documentation efforts as an independently funded component of program activities.

It is difficult to evaluate pregnancy prevention programs in the middle grades since even in school systems where the rates of early adolescent pregnancy are high, they are still statistically quite low. To document an impact on these rates would require a massive, intensive, and long-term intervention, probably targeted to a small population, given the time, money, and effort that would be involved. One key to evaluation in the middle grades, then, is to determine what short-term factors can be evaluated to show decreased risk of early parenthood and school leaving.

Evaluation: Process, Outcome, and Impact

Investigators use two major types of evaluation to assess risk prevention programs: process evaluation and outcome and impact evaluation. Process evaluation seeks to determine quite simply whether a program is taking place. Is the program doing what it said it would? How many planned activities, workshops, and meetings have taken place? How many services has the program offered? How many young people have received counseling? Is it reaching the intended population and if not, why not? Were the process objectives unrealistic? What changes can the program make to help it meet these objectives? Ideally, a process evaluation is "an ongoing dynamic tool to manage a program day by day, improving it as it moves along."[1] At its best, a process evaluation functions like a "smoke detector,

letting program staff know immediately when the planned intervention is not really happening."[2] Process evaluation requires maintenance of weekly logs listing number of classes, participants, activities. It can study participants by gender and race. However, it is important not to overreport in process evaluation: "Keep track of enough information," advised one project director, "to show that your program is happening so you'll be able to analyze problems, but not so much that it becomes really burdensome."

Pregnancy prevention programs seek to achieve both specific outcomes — short-term effects on participants' attitudes, knowledge and behavior — and specific impacts — long-term effects on participants' lives and life choices. Evaluations may assess the following outcomes and impacts:

Changes in knowledge or attitudes: Did the program change participants' knowledge about reproductive behavior? More specifically, did it increase their understanding of the time of month when a woman is at greatest risk of becoming pregnant? Did the program increase knowledge of contraception? In measuring changes in knowledge, it is probably best to use pre- and post-tests rather than self-reporting. It is also important to remember that changes in knowledge or attitudes are not the same as changes in behavior.

Changes in behavior: As a result of the program, did participants delay age of first intercourse, and by how much? Do they have sex less frequently? use contraception more consistently? use more effective methods? use more health services in the community? When trying to evaluate such changes in behavior, programs often encounter the faulty recall of teens, and the often sporadic nature of teen sexual activity can compound the problem.

Changes in communication patterns: Did the program change the frequency of communication between parents and children? the number of topics covered? the general degree of satisfaction on the part of parents and children?

Changes in personality: Did the program change some personality characteristic — ability to resist peer pressure? decision-making ability? self-esteem? Such changes are very difficult to accomplish and require long-range and intensive interventions that are often beyond the scope of program resources. Such changes are also very difficult to document.

Changes in pregnancy rate: Did the program lower the pregnancy rate? How much? Within what time span? For whom — participants who came the most often?

Changes in outcome of pregnancy: Did the program change the use of abortion? incidence of low birth weights? Did it keep participants in school? For how long?

Changes in indicators of school attachment and achievement: Did the program have a positive impact on rates of class cutting? truancy and dropping out? grade point averages? rates of course failure?[3]

Interpreting Evaluation Results

Determining whether a program has achieved its hoped-for outcomes and impacts means determining two things: that some change did take place and that this change

occurred as a result of the program. A program's impact is the change that occurred in participants minus the changes that would have happened anyway because of age, other programs, media events, and the like. Programs can use several methods to determine what change occurred as a result of program activities and services. The most scientific method is random assignment of individuals to the program and to a control group. *(Control group* is a term used exclusively in random assignment; when assignment is not random, *comparison group* is used.) Random assignment entails recruiting twice the number of teens desired for a program or class and randomly assigning half of them to the program and half to the control group. To achieve random assignment, the program can list all individuals alphabetically and then assign every other one to the program, or put all the names in a hat and draw out half the number.[4]

The most important reason to use random assignment is that it enables programs to avoid the "selectivity bias": the bias that occurs "when you allow teens to select themselves into experimental programs, using those who don't sign up as controls."[5] In the latter case, a program's impact might seem great, but the argument could always be made that it served only those young people motivated enough to enter the program and not the most needy. Job training programs often face this criticism.

Not using random assignment might also lead to underestimates of a program's impact, depending on the composition of the comparison group. For example, if 50 students at high risk of dropping out enter a dropout prevention program, and the program's dropout rate is compared with that of the school as a whole, the program might still have a higher rate than the school. This could occur because, while other students in the school may be at high risk of dropping out, many may not be. Thus, the comparison group rate may seem better than the program rate. Random assignment, then, not only helps avoid the bias of self-selection; it also provides a reasonable context in which to understand evaluation results.

Nevertheless, for three major reasons, random assignment may be undesirable. First, it may not be practical: a given school or program may not contain enough young people for two statistically large enough groups. Second, asking young people to oversubscribe for a program and then denying entrance to half of them may seem inappropriate. It is important to remember, however, that random assignment is not denying young people entrance into a program, but delaying their entrance. Furthermore, control group members are helping in the long run by helping determine the effectiveness of the program. Third, it may be unethical to deny services to students who are especially needy and at high risk. In this case, partial random assignment may be an acceptable alternative: a teen can be assigned to a program on the basis of the strong recommendation of a teacher or counselor, but the evaluation of impact should not include this student.

If random assignment is not possible, programs can use several other methods to understand their impact:

1. Compare program participants with a group of similar teens from the broader population. For example, the comparison group could be another class of students in the same school, or students in the same grade at another school in the community — provided that they

are similar in terms of race, gender and socioeconomic status. It is possible to have students choose their own comparison group — that is, give the names of friends they think are similar to them in most respects. (The Teen Outreach Program uses this method in sites where random assignment is not possible.)

2. Undertake before and after comparisons of participants.

3. Compare data on program participants with existing data sets. (See resources at the end of this chapter.)

What The Program Did Not Accomplish

Control or comparison groups help determine what programs accomplished. They also help determine what programs did not accomplish. Planners can learn a great deal from what the program failed to achieve: Was the plan too ambitious? Were the activities not intensive enough to bring about desired changes? The concept of "dosage" may be useful here. Would the program have been more effective had it given participants more? How much is effective? If one of the program's goals was to increase knowledge, a "booster" at some point in the future may be necessary, since knowledge gains are notoriously temporary.

Another important task of evaluation is to identify the participants who dropped out: How many did so? Who were they? Did they have common characteristics? Might they have remained with an extra dose? Determining who was lost is vital, since in the words of one researcher, "Loss is seldom random."

Impact evaluation must also address the questions of cost and cost-effectiveness: What did the program achieve, and at what cost? Could it have been achieved for less?

Evaluation can be a daunting task and one that intimidates program staff, especially those with no experience in it. Realistically, most program staff will need help in undertaking evaluation. Ideally, this is a task with which staff in collaborating agencies can provide major assistance. Help is also available from a number of the resources listed below.

Resources

Brindis, Claire et al. *Adolescent Pregnancy Prevention: A Guide Book for Communities.* Palo Alto, CA: Stanford University, Health Promotion Resource Center, Stanford Center for Research in Disease Prevention, 1990.

Contains an in-depth discussion of all aspects of evaluation, including choosing the evaluation design and the data collection method, and collecting and analyzing the data.

Card, Josefina J. ed. *Evaluating Programs Aimed at Preventing Teenage Pregnancies.* Los Altos, CA: Sociometrics, 1988.

Provides much information on carrying out effective evaluations.

Card, Josefina. J., R. T. Reagan, and P.E. Ritter, *Sourcebook of Comparison Data for Adolescent Pregnancy and Parenting Programs.* Los Altos, CA: Sociometrics, 1988.

Explains how to use available data to get comparison standards.

Davis, Clive M. et al. *Sexuality-Related Measures: A Compendium.* Lake Mills, IA: Graphic Publishing, 1988.

Provides more than 100 questionnaires, developed to measure a variety of sexuality-related traits, attitudes, and behaviors.

National Network of Teen Pregnancy Programs Doing Impact Evaluations (NationalNet), Social Research Applications, 170 State Street, Suite 280, Los Altos, CA 94022-2812.

A network of pregnancy prevention programs and programs serving pregnant and parenting teens interested in evaluating the impact of their interventions. It provides technical assistance (at little of no cost) to new and, to a more limited degree, existing programs. Assistance includes a review of program design, data collection instruments and evaluation plan.

Phillibe, Susan. *Evaluating Your Adolescent Pregnancy Program: How to Get Started.* Washington, DC: Adolescent Pregnancy Prevention Clearinghouse, Children's Defense Fund, 1989.

An introduction to the main issues involved in evaluation.

Teen Outreach Program, Association of Junior Leagues International, Inc. 660 First Avenue New York, NY 10016-3241.

The Teen Outreach Program evaluation manual is available for use by other programs.

Zabin, Laurie and Marilyn B. Hirsch. *Evaluation of Pregnancy Programs in the School Context.* Lexington, MA: Lexington Books, 1988.

A detailed study of evaluating school-based or school-linked pregnancy prevention programs; appendix contains the survey of students' health and sexuality knowledge, attitudes and behavior used in the evaluation of the Self Center (see Chapter 10).

Notes

1. Susan Phillibe, *Evaluating Your Adolescent Pregnancy Prevention Program: How To Get Started* (Washington, DC: Adolescent Pregnancy Prevention Clearinghouse, Children's Defense Fund, 1989).
2. Ibid.
3. Adapted from Phillibe (see note 1).
4. Phillibe (see note 1).
5. Ibid.

APPENDICES

Appendix A

Accepting Controversy: The New Jersey Family Life Education Story

A decade has passed since the New Jersey State Board of Education voted to require family life education instruction for all students attending public schools, except those whose parents withdrew them from the program. New Jersey was the second state in the nation to pass such a controversial requirement, and the Board's action caused a storm. Opponents, who, according to a reliable statewide poll, represented about 9 percent of New Jersey residents, fought the Board at every step. First, they voiced objections at a series of public hearings. One opponent even lay on the floor in front of Board members, hoping that state police would forcibly eject her in front of television cameras. The Board president calmly called a recess and left her by herself.

After the Board passed the mandate, opponents turned to the state legislature where they gained passage of a resolution, which led the Board to withdraw its requirement that schools cover certain broad topics by the end of grades 8 and 12. When they pressed the state assembly to pass a law that would nullify the Board's action, however, they failed by a margin of five votes. The mandate's proponents had triumphed — temporarily.

Still determined, opponents turned next to the courts for relief. They filed suit in state supreme court, claiming that the Board had overstepped its authority. The judges unanimously rejected their arguments. Opponents then appealed directly to the U.S. Supreme Court. The justices refused to hear the case because it did not touch a substantive constitutional issue. After exhausting possible judicial remedies, opponents returned to the state legislature, reminding members of upcoming elections. Two months before the program's implementation date, the speaker of the assembly announced that he would permit debate on a bill to nullify the mandate. Proponents — including representatives of statewide education, health, social service, youth and child advocacy organizations and members of the New Jersey Network for Family Life Education — rallied: for 24 hours, they bombarded the speaker with telephone calls. Realizing that the callers represented a majority of citizens, the speaker changed his mind and withdrew the bill. In September 1983, family life education was implemented in all of New Jersey's 600 school districts. Proponents had scored a victory for the children of New Jersey and their families.

Family life education has gained broad acceptance in New Jersey in the intervening years, with the state board reauthorizing the policy in 1985 and 1990 for five-year periods without any challenges. Nevertheless, opponents have not disappeared. Last year, they persuaded members of the assembly to pass a law that would require all school districts to "stress abstinence when teaching about pregnancy prevention and AIDS." Proponents lob-

bied against the bill on the grounds that it was redundant, would rob local districts of decision-making power and would discourage some districts from teaching about contraception and condoms. Network members organized, testified, and persuaded the Education Committee of the senate to take no action on the bill. In recent years, opponents of comprehensive family life education programs have shifted their attention from changing the state policy to influencing local decisions about curriculum. They frequently lobby local school boards to adopt curricula that focus solely on teaching abstinence from sexual intercourse until marriage (for example, Sex Respect and Teen Aid) as the districtwide curriculum.

Controversy will always surround family life and sexuality education. But the New Jersey experience demonstrates that proponents can secure and defend high-quality, comprehensive programs that will educate and protect children.

By Susan N. Wilson, executive coordinator of the New Jersey Network for Family Life Education, a resource, technical assistance and advocacy organization that supports comprehensive family life and sexuality education in public schools. The Network represents 60 statewide organizations and is located at Rutgers, the State University of New Jersey.

Appendix B

What We Know about the Effectiveness of Various Pregnancy Prevention Strategies

This handbook has described the effectiveness of various strategies in preventing pregnancy. Results of the research on these strategies are summarized below.

Family Life/Sex Education

Various studies have concluded that family life/sex education is "necessary but not sufficient": it neither influences initiation of sexual activity, frequency of teenage intercourse, nor teen pregnancy rates. It can, however, increase contraceptive use, especially among older teens.[1]

A four-year study of eight community- and school-based sex education programs has provided evidence that an experimental sex education class, employing role-playing and detailed discussion of sexual risks and feelings, did have an impact on participants' — especially male — behavior up to a year later, in terms of both choosing abstinence and in contraceptive use.[2]

School-Based and School-Linked Clinics

Several studies of school-based and school-linked clinics have shown that they can have a positive impact on delay of initiation of sexual activity, on contraceptive use among sexually active students, and on pregnancy rates. Evaluation of the Self Center in Baltimore showed a 26 percent decrease in pregnancy rates for students who were exposed to the program for two years or more, while rates for students in a control school rose 51 percent. The program also delayed the average age of onset of sexual activity by seven months.[3]

In a survey of school-based clinics by the Center for Population Options, contraceptive use among sexually active students was significantly greater in schools with clinics. The survey showed that clinics neither hastened the initiation of sexual activity nor increased the frequency of intercourse among sexually active students.[4] In St. Paul, Minnesota, at one of the country's oldest school health clinic programs, teen birth rates declined from 59 births per 1,000 adolescents to 37 per 1,000 from 1976–7 to 1984–5.[5]

Postponing Sexual Involvement

Results of an evaluation of the Postponing Sexual Involvement curriculum focusing on students considered at highest risk for early sexual involvement and premature pregnancy were positive. A group of students who had not yet had sex and did not take the curriculum were five times more likely to become sexually involved in the eighth grade than were similar students who were in the program. The program also had a lasting effect on those who

had not had sex before its implementation. By the end of the ninth grade, those who were in the program still were only two-thirds as likely as others to be sexually involved.[6]

Parent-Child Communication

Parent-child communication about sexuality has no proven impact on age at initiation of sexual activity. It does have an association with increased contraceptive use and use of abortion and adoption as alternatives to parenthood.[7]

Counseling

In an evaluation of the life skills counseling approach, investigators randomly selected two classes in 24 schools to receive 12-session life skills education or the regular curriculum. They took measurements before, just after, and six months after the program. For the group that received the life skills counseling, knowledge about birth control, communication with parents about pregnancy prevention, intentions to use contraception, and actual use were greater than for the control group — especially among students who initiated sex after the course. The evaluation recorded no differences in rates of sexual activity.[8]

Results of a three-year evaluation of Teen Choice, a family life education/small group counseling program, were encouraging: participants' knowledge had increased and sexually active students had improved their contraceptive use and had continued this improved use over time.[9]

Peer Education

Little evidence documents the effectiveness of peer education, but in one follow-up of a smoking prevention intervention, the same curriculum proved more effective in reducing smoking when a peer presented it than when an adult did so.[10]

Mentoring

Mentoring programs have not undergone as extensive evaluation as other risk prevention strategies. This is partially because they do not usually stand alone, but are one element of a more comprehensive approach to risk behavior. However, some evidence has emerged indicating that young people who flourish despite their disadvantaged backgrounds are those with a positive relationship with a parent or another significant adult.[11]

Service Learning

Service learning in itself has no proven effect in preventing risk behavior; but as a significant component of other programs, notably the Teen Outreach Program, it seems to be a promising strategy.

Life Options

Certain programs, employing a life options approach — the Teen Outreach Program is one of the best examples — have had a documented impact on teen pregnancy rates, as well as on rates of course failure, dropout, and suspensions.

Notes

1. Douglas Kirby, *Sexuality Education: An Evaluation of Programs and Their Effects*, vol. 1 (Atlanta: Bureau of Health Education, Centers for Disease Control, 1984); William Marsiglio and Frank L. Mott, "The

Impact of Sex Education on Sexual Activity, Contraceptive Use and Premarital Pregnancy Among American Teenagers," *Family Planning Perspectives* (Vol. 18, No. 4, July/Aug. 1986); and Deborah Anne Dawson, "The Effects of Sex Education on Adolescent Behavior," *Family Planning Perspectives* (Vol. 18, No. 4, July/Aug. 1986).

2. Marvin Eisen, Gail L. Zellman, and Alfred McAlister, "Evaluating the Impact of a Theory-Based Sexuality and Contraceptive Education Program," *Family Planning Perspectives* (Vol. 22, No. 6, Nov./Dec. 1990).

3. Laurie Zabin et al., "Evaluation of a Pregnancy Prevention Program for Urban Teenagers," *Family Planning Perspectives* (Vol. 18, No. 3, May/June 1986).

4. Center for Population Options, *School-Based Clinics Enter the '90's: Update, Evaluation and Future Challenges* (Washington, DC: Center for Population Options, 1989).

5. Asta M. Kenney, "Teen Pregnancy: An Issue for School," *Phi Delta Kappan* (June 1987).

6. Marion Howard and Judith Blamey McCabe, "Helping Teens Postpone Sexual Involvement," *Family Planning Perspectives* (Vol. 22, No. 1, Jan./Feb. 1990).

7. Lynne M. Casper, "Does Family Interaction Prevent Adolescent Pregnancy?" *Family Planning Perspectives* (Vol. 22, No. 3, May/June 1990).

8. R. Barth et al., "Preventing Teenage Pregnancy with Social and Cognitive Skills." Unpublished paper, 1990, as cited in "Reducing Adolescent Pregnancy: The Next Steps for Program Research and Policy," *Family Life Educator* (Vol. 9, No. 1, Fall 1990).

9. Inwood House Community Outreach Program (Teen Choice), Summary Report for the 1988-89 School Year (New York: Inwood House Community Outreach Program, 1989).

10. Russell V. Luepker et al., "Prevention of Cigarette Smoking: Three-Year Follow-Up of an Educational Program for Youth," *Journal of Behavioral Medicine* (Vol. 6, No. 1, 1983).

11. M. Rutler, C. Izard, and P. Read, *Depression in Young People: Developmental and Clinical Perspectives* (New York: Guildford Press, 1985), as cited in Joy G. Dryfoos, *Adolescents at Risk: Prevalence and Prevention* (New York: Oxford University Press, 1990).

Appendix C

Summary of Statistics Relating to Teen Sexual Activity and Pregnancy and the Negative Long-Term Consequences of Too-Early Pregnancy and Parenting

Teen Pregnancy and Birth Rates

1 million U.S. teens aged 15–19 get pregnant every year — one in 10. Five out of six of these pregnancies — 92 percent of all pregnancies among unwed teenagers — are unplanned.[1]

The U.S. teen pregnancy rate is more than double that of the closest industrialized country: 96 pregnancies per 1,000 teens aged 15–19, compared with 45 per 1,000 in England and Wales, and 14 per 1,000 in the Netherlands. The pregnancy rate among white teens alone in the U.S. is also much higher — 86 per 1000.[2]

Teen birth rates in the United States are also higher than teen births rates in other industrialized countries, but not because teens in other countries choose abortion in greater proportions. In fact, U.S. girls aged 15–19, both African American and white, have higher rates of abortion than teens in six other industrialized countries.[3]

In 1988, there were 54 births per 1,000 U.S. teens aged 15–19-year-olds.[4]

Births to U.S. teens, aged 15–19, increased 5 percent from 1985 to 1988. Births to teens under age 15 rose 8 percent, and births to teens aged 15–17 rose by 9 percent.[5]

Approximately one out of 12 births in 1988 were to unmarried teenagers.[6]

U.S. girls under 15 are five times more likely to become pregnant than teenage girls under 15 in any other industrialized country for which data are available.[7]

If 1985 rates continue, one in five young women will give birth by age 20,[8] and one in four will experience a pregnancy before leaving high school.[9]

Almost half of teen pregnancies occur within six months of the adolescent's first sexual experience.[10]

Sexual Activity Among Teens

The proportion of teens aged 15–19 reporting that they had initiated sex rose from 32 percent in 1970 to 47 percent in 1982 and 53 percent in 1988. For 15–17-year-old females, the rate increased from 33 percent in 1982 to 38 percent in 1988.[11]

Approximately one third of 15-year-old boys[12] and one quarter of 15-year-old girls have had sexual intercourse.[13]

Among 10–14-year-olds, 17 percent of males and 5 percent of females have had sex.[14]

Contraceptive Use Among Young Teens

Only 31 percent of girls who have sex before age 15 use any method of birth control at first intercourse. Of those 15–17, 52 percent do so.[15]

Among teen males, 48 percent of those who have first intercourse between the ages of 12 and 14 and 75 percent of those who have first intercourse before the age of 12 use no contraception at first intercourse.[16]

The Relationship Between School Achievement, Socioeconomic Status, and Too-Early Parenthood

African American, white, or Hispanic, 20 percent of young women from families with below poverty incomes and who have poor academic skills are mothers, compared with 3–5 percent of those who come from above-poverty income families and who have solid academic skills.[17]

The Negative Impacts of Sexual Activity, Pregnancy and Parenthood

Health

Only half of teen mothers get prenatal care. Pregnant teenagers, especially those under 15, are at risk of toxemia, anemia, birth complications and premature delivery.[18]

One-quarter of all high school graduates will have contracted a sexually transmitted disease by the time they graduate from high school.[19]

Educational Achievement and Dropping Out of School

Younger teen mothers are less likely than older teen mothers to be high school graduates. Of teens who gave birth in 1986, 38 percent of all 19-year-olds, 54 percent of all 18-year-olds and 84 percent of all 17-year-olds had not completed high school.[20]

Only 45 percent of teens who have their first child before age 15 have received their diploma or equivalency degree by their mid 20s, compared with 52 percent of those who give birth at age 18 and 90 percent of those who give birth at age 20 or older.[21]

Only one in five adolescent mothers who are not high school graduates when they have their first child finish their secondary education without delay.[22]

Only 2 percent of young women who become parents before 20 will graduate from college.[23]

Of young women who become parents as teens, 33 percent will not have received their diploma or equivalency by the time their first child enters high school.[24]

Over half of all young women who leave school before graduating are pregnant or parenting.[25]

Socioeconomic Status and Living Arrangements

Fewer than 10 percent of African American teen mothers live with the father of their child; 50 percent of white teen mothers do so.[26]

Overall, 67 percent of teen mothers and their children live in poverty.[27]

Some 59 percent of women who received Aid For Dependent Children payments in 1988 were 19 or younger at the birth of their first child.[28]

Teen mothers earn about half the income of those who first give birth in their 20s; women who first give birth as teens work in lower-status occupations, accumulate less work experience, receive lower hourly wages, and earn less annually.[29]

The Children of Teen Parents

One in seven babies born to teen mothers under 15 have low birth weight.[30]

Of the low birth weight babies who do survive, 25 percent are at high risk of being permanently disabled mentally or physically.[31]

The children of teen parents need more educational support services and perform less well in school than do the children of older mothers.[32]

The children of teen mothers are more likely than others to become teen mothers themselves.[33]

Notes

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2. Elise Jones et al., "Teenage Pregnancy in Developed Countries: Determinants and Policy Implications, *Family Planning Perspectives* (Vol. 17, No. 2, Mar./Apr. 1985).
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11. Jacqueline Darroch Forrest and Susheela Singh, "The Sexual and Reproductive Behavior of American Women, 1982-1988," *Family Planning Perspectives* (Vol. 22, No. 5, Sept./Oct. 1990).

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17. Karen Pittman, *Preventing Adolescent Pregnancy: What Schools Can Do* (Washington, DC: Adolescent Pregnancy Prevention Clearinghouse, Children's Defense Fund, 1986).

18. Adolescent Pregnancy Prevention Clearinghouse, *Adolescent Pregnancy: An Anatomy of a Social Problem in Search of Comprehensive Solutions* (Washington, DC: Children's Defense Fund, 1987).

19. National Institutes on Allergies and Infectious Disease Study Group, *Sexually Transmitted Diseases — Summary and Recommendations* (Washington, DC: U.S. Department of Health, Education and Welfare, National Institutes of Health, 1980) as cited in Carnegie Council on Adolescent Development, *Turning Points: Preparing American Youth for the 21st Century* (New York: Carnegie Corporation, 1989).

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21. Frank L. Mott and William Marsiglio, "Early Childbearing and Completion of High School," *Family Planning Perspectives* (Vol.17, No.5, Sept./Oct. 1985).

22. Dawn M. Upchurch and James McCarthy, "The Effects of the Timing of a First Birth on High School Completion" (Paper presented at the annual meeting of the Population Association of America, Baltimore, 1989), as cited in McGee and Blank (see note 20).

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24. Frank Furstenburg, Jr., J. Brooks-Gunn and S.Philip Morgan, "Adolescent Mothers in Later Life," *Family Planning Perspectives* (Vol. 19, No. 4, July/Aug. 1987).

25. Upchurch and McCarthy (see note 22).

26. Child Trends, *Facts at a Glance* (Washington, DC: Child Trends, November 1990).

27. "The President's Column," *The Nation's Health* (Vol. 20, No. 9, Sept. 1990).

28. Child Trends (see note 26).

29. Center for Population Options (see note 23).

30. Child Trends (see note 26).

31. Adolescent Pregnancy Prevention Clearinghouse (see note 18).

32. Asta M. Kenney (see note 9).

33. Cheryl D. Hayes, *Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing*, Vol. 1 (Washington, DC: National Academy Press, 1987).

Appendix D

Resource Organizations

Many of the resources described throughout this handbook are available from the organizations listed below.

Alan Guttmacher Institute, 111 Fifth Avenue, New York, NY 10003; (212) 254-5656.

Research, policy analysis, and public education organization in the reproductive health field. Publishes *Family Planning Perspectives* six times a year.

Association of Junior Leagues International, Inc., 600 First Avenue, New York, NY 10016-3214; (212) 683-1515.

Organization committed to promoting voluntarism. Conducts several programs geared towards improving the educational experiences of at-risk youth, including the Teen Outreach Program and the Middle School Improvement Program.

Carnegie Council on Adolescent Development, 11 Dupont Circle NW, Washington, DC 20036, (202) 265-9080.

Conducts research on adolescent development. Published *Turning Points: Preparing American Youth for the 21st Century* in 1989, and is preparing a work on positive youth development.

Center for Early Adolescence, Suite 233, Carr Mill Mall, Carrboro, NC 27510; (919) 966-1148.

Disseminates information about early adolescence and middle grades restructuring. Produces a quarterly newsletter that lists programs, research, books, films, and conferences for professionals who work with teenagers.

Center for Population Options (CPO), 1025 Vermont Avenue NW, Washington, DC 20005, (202) 347-5700.

National organization with primary objective of reducing the incidence of unintended teenage pregnancy and preventing sexually transmitted diseases. Provides training in the development and implementation of family life education programs; developed and distributes *Life Planning Education: A Youth Development Program*; and operates Support Center for School-Based Health Clinics.

The Children's Aid Society National Adolescent Sexuality Training Center, 350 East 88 Street, New York, NY 10128; (212) 876-9716.

National training center offering intensive training to social services and youth-serving

institutions interested in establishing programs offering young people and their families a comprehensive and holistic approach to pregnancy prevention.

Children's Defense Fund (CDF), 122 C Street NW, Washington, DC 20001; (202) 628-8787.

National child advocacy and research organization; operates Adolescent Pregnancy Prevention Clearinghouse; monitors government activities; has information on subsidized care and federal and state policies; has wide array of publications.

Education, Training, Research Associates (ETR), P.O. Box 1830, Santa Cruz, CA 95061, (1-800) 321-4407.

Family life and health education organization offering training and technical assistance in basic health education preparation; development and evaluation of educational approaches; dissemination of materials on family life education, AIDS, and adolescent pregnancy prevention; publishes *Family Life Educator* quarterly. Network Publications, a division of ETR, is the country's largest publisher of family life and health education materials and resources.

Girls Incorporated (formerly Girls Clubs of America), 30 East 33 Street, New York, NY 10016; (212) 689-3700.

National organization for girls that developed and conducts a four-part adolescent pregnancy program, including *Growing Together* for 9–12 year-old girls; and *Will Power / Won't Power* for 12–14 year-old girls. These are currently in use in Girls Incorporated affiliates nationwide, and will be available for use by non-affiliates at some future date.

National Organization for Adolescent Pregnancy and Parenting, Inc.(NOAPP), 4421-A East West Highway, Bethesda, MA 20814; (301) 913-0378.

A national membership network dedicated to preventing adolescent pregnancy and problems related to adolescent sexuality, pregnancy and parenting. It sponsors an annual conference and other training for professionals concerned with adolescent pregnancy and parenting and publishes a newsletter, *NOAPP Network*.

National Resource Center for Middle Grades Education, College of Education, University of South Florida, College of Education, 4202 Fowler Avenue, Tampa, FL 33620-5650; (813) 974-2530.

Publishes and distributes a wide range of materials on middle grades education and restructuring; provides technical assistance to school districts undertaking change; holds an annual symposium for middle-level educators.

National Urban League, 500 East 62 Street, New York, NY 10021; (212) 310-9214.

National organization working to ensure equal opportunities for socially and economically disadvantaged individuals and groups. Has conducted several national programs addressing adolescent pregnancy and parenting, including the Adolescent Male Responsibility Project, a public awareness campaign to encourage responsible male involvement in pregnancy prevention and parenting.

Search Institute, 122 West Franklin, Suite 525 Minneapolis, MN 55404; (612) 870-9511.

Research organization providing information on programs about adolescents and family life to educators and social service professionals. Developed and distributes *Human Sexuality: Values and Choices*, a family life education curriculum for middle grades students and their parents.

Sex Information and Education Council of the United States (SIECUS), 130 West 42 Street, Suite 2500 New York, NY 10036; (212) 819-9770.

Operates extensive library on human sexuality and sex education; produces bibliographies on specific subjects and a number of publications, including a monthly newsletter.

Gerald R. Ford, Honorary Chairman of the Board (1986-1989) and Chairman of the Board (1977-1985): President of the United States, 1974-1976

Sol M. Linowitz, Honorary Chairman of the Board: Senior Counsel, Coudert Brothers; former U.S. Ambassador to the Organization of American States and Chairman of the Board, Xerox Corporation

Robert O. Anderson, Chairman Emeritus of the Board: President, Hondo Oil and Gas Company

Luther H. Foster, Chairman of the Board: President Emeritus, Tuskegee University

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Stephen F. Moseley, President and Chief Executive Officer

Joseph S. Iseman, Secretary of the Corporation: Counsel to Paul, Weiss, Rifkind, Wharton and Garrison

Aida Alvarez: Vice President, The First Boston Corporation

Barbara B. Blum: President, Foundation for Child Development

John Brademas: President, New York University; former U.S. Congressman

Lincoln Chen: Taro Takemi Professor of International Health and Chairman, Department of Population Sciences, Harvard School of Public Health

Roberta N. Clarke: Associate Professor of Marketing, School of Management, Boston University

Alonzo A. Crim: Professor, Benjamin E. Mays Chair, Georgia State University; former Superintendent of Schools, Atlanta, Georgia

M. Joycelyn Elders: Director, Arkansas Department of Health

Marie Davis Gadsden: Chair Emeritus, OXFAM; former Deputy Director, National Association for Equal Opportunity in Higher Education/A.I.D. Cooperative Agreement

Juliet Villarreal Garcia: President, Texas Southmost College

Frederick S. Humphries: President, Florida A&M University

Walter F. Leavell: President, Charles R. Drew University of Medicine and Science

F. David Mathews: President, Kettering Foundation; former U.S. Secretary of Health, Education, and Welfare

James E. O'Brien: Of Counsel, Pillsbury, Madison & Sutro

James A. Perkins: Chairman of the Board and Chief Executive Officer, International Council for Educational Development

Cassandra A. Pyle: Executive Director, Council for International Exchange of Scholars

Frank H.T. Rhodes: President, Cornell University

Rita M. Rodriguez: Director, Export-Import Bank of the U.S.

Joseph E. Slater: President Emeritus and Senior Fellow, Aspen Institute for Humanistic Studies; Chairman, The John J. McCloy International Center

Willard Wirtz: Partner, Friedman and Wirtz; former U.S. Secretary of Labor

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